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Changing the way that doctors learn to care for people who
are dying.

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How doctors learn to care for people who are dying

The development of palliative medicine as a discrete and recognizable medical specialty in the UK, in 1987, presented new challenges to medical educators. Until that time the main focus of 20th century medical education had been on knowledge and skill that were focussed on cure. The hospice movement grew out of an awareness that the *care* of people who were dying fell far short of what 20th century society deemed acceptable and as such, a new dimension to the training of doctors of the future was realised.

Because of the technological advances in medicine towards the end of this century, medical education in this area focused on techniques for the control of symptoms and there is a real fear by some that palliative medicine will merely become synonymous with symptom management. From an educational point of view that has some attractions – it is far easier to gain knowledge of drugs and how to use them than it is to try and understand the lifeworld of someone close to death. By concentrating on some of the broader aspects of the care of people who are dying I have endeavoured to expand our understanding of what is meaningful in our teaching and learning in this area of medical practice.

This thesis represents the development of educational strategies for teaching about care at the end of life and an understanding of significant elements that are essential for the evolution of an effective approach to the provision of care for people who are dying.

Survey work on the educational needs of general practitioners and a literature review of education in palliative medicine, identified the extent and deficiencies of teaching and learning in this area. The development of courses for general practitioners, evaluation of those courses and the development of multi-disciplinary approaches to education in this area are reported. My earlier work had shown that the greater part of teaching in palliative medicine was didactic and knowledge based. It is essential to continue to give information in a way that learners can access and use to develop their knowledge base. This has been undertaken by the publication of 28 articles, booklets and book chapters on varying aspects of symptom management and palliative care (see appendix).

Building on the experience of postgraduate and continuing medical education, deficiencies in undergraduate education in this area were addressed. I became part of a small group of doctors from the Australia and New Zealand Society for Palliative Medicine who wrote an undergraduate medical palliative care curriculum that has received endorsement from all the Deans of medical schools in Australia and New Zealand.

By developing some of the aspects contained in that document, an innovative and deeper approach to undergraduate education in palliative care has been developed.

This collection of work represents a clarification and repositioning of key components of the process of education that is necessary for the development, not only of palliative physicians but also of doctors entering any specialty where people will die.

By emphasizing that learning does not merely need to take place in the science of palliative care but also in the art of palliative care, this work contributes substantially to knowledge in this area and has been influential in educational growth and development.

R D MacLeod,
Wellington, New Zealand.
October 2001.

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Preface

This collection of work represents an interest in education in palliative care over the last ten years. These papers are written either by myself or in collaboration with colleagues in Britain and New Zealand. During those years the way in which palliative care is taught and learned has changed and continues to change. The overview of the work submitted here describes the rationale behind the development of new approaches to the teaching and learning of care at the end of life. In many ways this collection represents a personal journey – one that involves investigation, growth, research and evaluation. By publishing these papers and promoting discussion in this area of education I have made an original contribution to the changing way in which doctors are taught and learn to care for people who are dying and into our understanding of the nature of learning to care for those people. The papers are listed here in chronological order. Throughout the text of the overview they are referenced along with other relevant papers but appear in the reference list in bold. I declare that I am the author of the papers contained in thesis unless otherwise stated. All references documented have been consulted in the writing of these papers. References appear in the texts in the form required for each individual journal. The papers have all been published in peer reviewed journals.

MacLeod, R.D., Nash, A.: 1991 : Teaching palliative care in General Practice - a survey of education needs and preferences. Journal of Palliative Care 7: 4, 9-12. (reference 6)
(RDM 70% - AN 30%)

MacLeod, R.D., Nash, A.: 1992 : "Taking the lid off" -observations of the process of palliative care education for General Practitioners. Postgraduate Education for General Practice 3, 28-3 (reference 9)
(RDM 60% - AN 40%)

James, C., and MacLeod, R.D.: 1993 : The problematic nature of education in palliative care. Journal of Palliative Care 9:4, 5-10 (reference 10)
(RDM 60% - CRJ – 40%)

MacLeod, R.D.: 1993 : Education in palliative medicine : a review. Journal of Cancer Education 8: 4, 309-312 (reference 11)

MacLeod, R.D., Nash, A.: 1994 : Multidisciplinary palliative care education. Journal of Interprofessional Care 8:3, 283-288 (reference 12)
(RDM 70% - AN 30%)

MacLeod, R.D., Nash, A. and Charny, M.: 1994 : Evaluating education in palliative medicine. European Journal of Cancer Care 3: 163-168 (reference 14)
(RDM 60% - AN 30% - MC 10%)

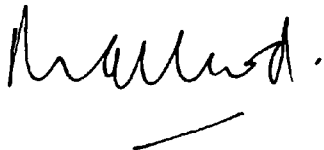
MacLeod, R.D.: 1997 : Teaching holism in palliative care and hospice. American Journal of Hospice & Palliative Care 14:1, 12-16 (reference 36)

MacLeod, R.D., James, C.R.: 1997 : Improving the effectiveness of palliative care education. Palliative Medicine 11:5, 375-380 (reference 38)
(RDM 60% - CRJ 40%)

MacLeod, R.D., Robertson, G.: 1999: Teaching about living and dying.
Education for Health 12:2, 185-192 (reference 65)
(RDM 80% - GR 20%)

MacLeod, R.D.: 2000 : Learning to care: a medical perspective. Palliative Medicine 14:3, 209-216 (reference 66)

MacLeod, R.D.: 2001 : On reflection: how doctors learn to care for people who are dying.
Social Science & Medicine 52, 1719-1727(reference 67)

A handwritten signature in black ink, appearing to read 'R. MacLeod', with a horizontal line underneath.

Roderick D MacLeod

Acknowledgements

This work is the result of discussions, reflections, collaborations and investigations undertaken with a number of people.

Chris James has been a constant friend, mentor and guide throughout this process and despite being so far away has maintained his enthusiasm and support in an impressive manner.

Working with Ann Nash in Bath was the starting point for much of the early thinking recorded here. Her pursuit of excellence in teaching palliative care was infectious and stimulating and I am indebted to her.

My colleagues at the Mary Potter Hospice, Wellington have been encouraging in many ways, particularly Gaye Robertson who has supported me in the development of the undergraduate programme along with our colleagues at the Wellington School of Medicine, University of Otago.

The completion of this thesis was facilitated by the Lions Clubs of New Zealand awarding me, in 2000, the inaugural Lloyd Morgan Charitable Trust Fellowship. This Fellowship was set up for the advancement of health and well-being of people residing in New Zealand and the Trust were keen for me to continue research into how doctors care for those who are dying.

The greatest debt of gratitude though, is to Jenny, whose love and friendship have sustained me throughout these years and to our children, Katy, Lucy, Sally and Meg, who have tolerated much during the completion of this collection. They are my constant sources of strength and despite what I take to be a degree of bewilderment as to why someone approaching 50 should want to undertake a PhD, have been supportive throughout.

Changing the way that doctors learn to care for people who are dying: an overview

Historical background

Over the last 50 years, advancements in medical science have encouraged a different focus for health care. Developments in all fields of medicine now mean that doctors emerging from medical school face new challenges and a wide range of curative options, hitherto unknown or even imagined. Coincidentally, with these advances have come changes in thinking and attitudes in medical education. It has become apparent that the skills and attitudes required for a good doctor are not something that can be acquired in a few years at medical school. The focus has changed from caring for people in their communities to care in the sterile and often unfriendly environment of a modern hospital. Part of the difficulty facing medical teachers is that medical education had become focussed on “*a ridiculously long period of apprenticeship or the mind numbing requirements of some of [its] specialist examinations*”(p2)¹. It was partially in response to this change in attitude that the modern hospice movement developed. In the 1960s, there were a few long-established Catholic hospices in Britain and Eire, 10 Marie Curie homes and 19 beds allocated for terminal care at the Royal Cancer Hospital, London in England for people who were dying². However, it was the opening of St Christopher’s Hospice in Sydenham in 1967 that is noted as the defining moment of the start of the modern hospice movement. Initially the vision or mission of early hospices resonated with public concern about the care of people who were dying. There is no doubt that its appeal was to individual’s personal beliefs and experiences but as the ideals and ideas spread the initial *ad hoc* separatist development generated organisational support on a national level which assisted the dissemination of the principles outlined by Cicely Saunders². In the UK, in 1972, the Department of Health and Social

Security held a national symposium on the 'Care of the Dying' and in 1976 the first courses on the 'Care of the dying patient and their family' were organised by the English National Board (Nursing and Midwifery). In 1980, the Standing Medical Advisory Committee on Terminal Care produced the Wilkes Report³ which addressed the increase in focus on in-patient hospice that was developing and suggested a broadening of education for medical students and practitioners in terminal care. In 1987, *Palliative Medicine*, a new multi-disciplinary journal, edited and printed in Britain was first produced. In the same year, continuing interest in hospice building saw 300 hospice projects in existence in the UK². The development of palliative medicine as a discrete and recognisable medical subspecialty within general medicine by the Royal College of Physicians (UK), also in 1987, presented new challenges to medical educators. This development meant that terminal care and palliative care became integrated into career development for the first time. Until that time the main focus of 20th century medical education had been on knowledge and skill that were focussed on disease and the cure of disease. The modern hospice movement grew out of an awareness that the care of people who were dying fell far short of what 20th century society deemed acceptable and, as such, a new dimension to the training of doctors of the future was anticipated.

Palliative care has developed most rapidly in the affluent regions of the world – Western Europe, North America, Australia, New Zealand and Japan but work continues to develop similar services in poorer countries, developing models that best suit their national needs. Educational initiatives have been seen in many countries. A Clinical Reader in Palliative Care was appointed at Oxford University in 1988. The first Diploma in Palliative Medicine was offered by the University of Wales in 1990⁴. There are now a number of academic departments of Palliative Care/Medicine in Britain, Australia and the United States with

Chairs from the disciplines of medicine, nursing and sociology. There are currently 19 programmes in the United States with 33 places specifically for palliative medicine training (personal communication J. A. Billings).

Because of the technological advances in medicine at the end of the 20th and beginning of the 21st century, medical education in palliative care has tended to focus on techniques for the control of symptoms⁵. There is a real fear by some that palliative medicine will merely become synonymous with symptom management. From an educational point of view that has some attractions – it is far easier to gain knowledge and an understanding of drugs and how to use them than it is to try and understand the lifeworld of someone close to death. By concentrating on some of the broader aspects of the care of people who are dying I have endeavoured to expand our understanding of what is significant in our teaching and learning in this area of medical practice.

Personal learning

Adult learners accumulate a growing reservoir of experience which can provide an effective context for the acquisition of new knowledge and skills. My role as a general practitioner stimulated learning in that the demands of everyday practice warranted a further explanation of what it was that I was trying to achieve. My own interest in palliative medicine was developing in the 1980s as I worked as a general practitioner in rural Norfolk in the East of England. During that time it became clear to me that there were significant areas of the care of people who were dying that had been inadequately dealt with in my education. In 1988, in response to my own need for further exploration, I elected to undertake a period of prolonged study leave and worked in a number of community based hospice programmes in the South of England. This culminated in an unpublished report for

the Department of Health (England and Wales) entitled '*Palliative care in the community*'. What became apparent to me then was that if a difference was to be made in this area of care then I would need to have a clearer understanding of educational principles and practice than I was currently aware of.

At that time there were no postgraduate courses available in palliative care but I was able to pursue my interest through the Centre for Medical Education at the University of Dundee with the Diploma in Medical Education. I subsequently continued that formal study with a Masters' degree in Medical Education with a thesis entitled '*Teaching postgraduate palliative medicine*'⁵.

Developing programmes

In 1989, having decided to pursue a career in palliative care, I was appointed Physician in Palliative Medicine and subsequently Medical Director at the Dorothy House Foundation in Bath, England. This was a community-based hospice programme where the teaching of palliative care had been predominantly for nurses, by nurses. Whilst holding that position it was more appropriate to focus on postgraduate and continuing medical education (CME) as there was no involvement by that organisation with any undergraduate medical school. I took my initial educational task as a survey of general practitioners (GPs) in the Bath District Health Authority to determine their educational needs and preferred methods of learning in palliative care, in order to develop an appropriate education programme⁶. In undertaking this survey it was hoped to identify whether GPs could relate their needs to those areas identified as having implications for practice⁷. These are, a different context for learning (adults generally learn and function in settings where situation-specific skills are required in the solution of relevant problems), a change in the learner (adult learners need

to be self-directing, they already have a large reservoir of knowledge, they look for knowledge with direct relevance to their needs and they have an internal motivation to learn) and the process of learning has different non-cognitive factors affecting learning (pacing, meaningfulness and motivation)⁸.

The survey⁶ confirmed initial ideas about the content of the programme. There was support for the hypothesis that the majority would favour didactic approaches and would feel generally uncomfortable with experiential methods. The issue of professionals' needs in stressful situations proved to be a surprisingly strong one. Following this research a course was designed for GP principles and trainees. The organisation already had a well-developed programme in palliative care education but nothing specifically for doctors. The courses began with information giving sessions (for example, symptom management or theories about grief and loss) that slowly evolved into more experiential work. We explored the personal and professional problems encountered when caring for dying patients and their grieving families using a variety of teaching approaches. These included more formal, didactic presentations, small group work, personal reflection, story telling, role-play and sculpting. Evaluation of that work⁹ acknowledged the personal investment doctors make when caring for dying and grieving people and participants identified personal growth and the need for further supportive exploration. In that work the development of reflective practice when caring for people who are dying was the driving principle – the ability to continually learn and develop by creatively applying current and past experiences and reasoning to unfamiliar events. That process consists of three activities; re-framing and re-working the problem from different perspectives; establishing where the problem fits into existing knowledge; and understanding the elements and implications present in the problem, its solution and consequences. The combination of 'traditional' knowledge (that gained from school or study) and experiential knowledge

combine to enable doctors to feel confident and competent in their care of dying people. A creative process then develops in response to new meanings, insights and perspectives gained through reflection on current and past experiences.

During the first two to three years of my appointment in Bath it became clear that there were a number of issues that were unique to education in palliative care that needed to be addressed. The issues included; the lack of a long tradition and adequate conceptualisation of palliative care; the significance of psychological, emotional and spiritual aspects; the importance of, but inadequate understanding of symptom control; the fact that palliative care is not curative in the accepted sense; its multi-professional nature; the range of different settings of palliative care and the fact that palliative caregivers have to perform their duties in situations where the emotional and psychological demands on them may be immense¹⁰.

A review of education in palliative medicine that identified the extent of teaching and learning in this area¹¹ showed that very little had been published about the actual structure of courses available and there was little emphasis on evaluation. There were wide variations both between countries and within countries.

Continued development of the programme in Bath is illustrated by work describing multi-disciplinary education in palliative care¹². At that time there were no reports of multi-disciplinary teaching or learning in this area. Mindful of the unique features of palliative care education this programme was developed in the belief that multi-disciplinary education can be effective in overcoming barriers to collaboration and therefore provide more effective and efficient team work. This outcome is particularly so if it explores

similarities and differences in roles, skills, knowledge and ideology and recognises the complementary skills and resources of different professions. It is also more effective if it allows communication between the whole group and has institutional or organisational support.

The courses were developed with these barriers in mind so that an increase in understanding between professions, promotion of teamwork/cooperation, increase in knowledge and development of practical skills were all pursued. Evaluation of those courses indicated beneficial outcomes in teamwork anticipating improved communication and greater understanding of roles. Social Cognitive Theory (SCT)¹³ acknowledges the social (interactive) aspects of learning and is particularly relevant to this type of programme. SCT suggests that our actions, learning and functioning, are the result of a continuous, dynamic reciprocal interaction among three sets of determinants: personal, environmental (situational) and behavioural. The relative influences exerted by each of the three sets of factors will vary for different activities, different individuals and different circumstances. In working with teams of professionals we were able to identify changes within the teams and those teams were able to set these changes within a context for themselves. Environmental influences can affect people apart from their behaviour, as when thoughts and feelings are modified through observing others' behaviour (modelling), teaching and social persuasion¹³. More specific issues identified were an improvement in awareness, empathy and sensitivity, particularly to psychosocial issues.

Evaluation and change in practice

The literature in this area of education indicates that little work had been undertaken in the evaluation of courses available. With my colleagues in Bath I evaluated our programmes both qualitatively and quantitatively, demonstrating shifts in confidence and perceived

ability to cope in this area of care and illuminating a reflective component to participants clinical activities¹⁴. By focussing on the more qualitative aspects of evaluation we showed that participants identified elements of personal change in their ability to cope with the care of dying people and their families at the close of the workshop. Both personal and professional changes were maintained and developed over several months – changes in self-rated confidence in dealing with the physical and psychological problems of palliative care and changes in participants' perceived and reported ability to cope with dying patients and their families. Learning triggered by such a course can continue for some time if existing knowledge is reinforced and reflection in and on practice is encouraged. Such reflection is central to the art by which practitioners sometimes deal with uncertainty, uniqueness and value conflict¹⁵. It is unusual to find evidence of change in practice following courses of this nature; partly because they are rarely evaluated and partly because evaluation is not specific. Recent reviews¹⁶ identified that out of 2561 articles published in connection with continuing medical education or continuing professional development only 118 contained any information about outcomes. Further analysis reveals only 16 that could be linked with attainment of the aims of the course. Of significance to this area of teaching and learning were studies that showed change in behaviour in;

- collaborative care and multi-disciplinary working;
- knowledge and practice relating to pain management;
- expansion of practitioners' professional roles.

Such programmes have been shown to make a difference but further work needs to address particular predisposing factors (such as why practitioners want to change), enabling features (such as the rehearsal of desirable behaviours), reinforcing features (such as reminders and feedback), assessment of the needs of practitioners and their patients and a consideration of the influence of relevant contextual factors¹⁶. A taxonomy of learning and

change has been suggested that classifies change in four dimensions¹⁷. Accommodation was typically the type of change requiring a small and simple act of acceptance.

Adjustment requires a more complex adaptation and more time and effort to accomplish that accommodation. Redirection requires adding, subtracting or changing a major element of one's life or practice. Transformation requires restructuring and redefinition of many elements in a physician's personal or professional life.

Changing the focus

Earlier work⁵ had shown that the majority of teaching in palliative care was didactic and knowledge based. It is fundamental to continue to give information in a way that learners can access and use it to develop their knowledge base. I have contributed to this change by the publication of books and articles on varying aspects of symptom management and palliative care¹⁸⁻³⁴. However, gaining knowledge is much more than acquiring information. It should be an active process on the part of the learner that takes information and makes it personal – not a quantitative accumulation of facts but a qualitative transformation of information into an elaborate structured entity. Providing information in a form that is readily accessible to practitioners³⁵ aids this process.

Through my exploration and understanding of education in this field it became more apparent that a broader approach to palliative care education was needed than was illustrated in the literature. A presentation at the inaugural meeting of the International Institute for Hospice Studies in Adelaide, Australia³⁶, outlined some of the different aspects of care that needed to be taught and learned and emphasised a holistic approach to teaching about care at the end of life. Teachers have a natural inclination to tell learners what they know and show them what they can do, but in this area of practice each practitioner will need to be enabled to utilise their own learning for differing situations. By encouraging

reflection on learning³⁷, returning to the experience, attending to the feelings evoked and then re-evaluating the experience, we may gain a deeper understanding of what it is we know and how we know it. By trying to pass on what we know and how we practice it we will gain a deeper understanding of the nature of life and perhaps the nature of death.

Lack of evaluation of palliative care education, didactic teaching and a perception of a lack of effectiveness led to work on improving the effectiveness of palliative care education³⁸.

By revisiting and reviewing previous work¹⁰ the problems of delivering effective education in this area were identified. Because much of what should be taught in palliative care lies within the hermeneutic/interpretive domain, knowledge assumes a different form to that which is normally learned in medical education. Moral, ethical and personal knowledge makes up a large part of what must be learned so merely simplifying education to components to be learned becomes problematic for teachers. 'How can we achieve effectiveness when it is not clear what we are trying to effect?'³⁸. Because of these issues it may be seen that palliative care education is beyond evaluation, so wide ranging are its different purposes, processes and content. The identification of performance indicators may be one way in which some of these problems may be addressed, assisting with the task of evaluating palliative care education and establishing its effectiveness and appropriateness. Subsequently others have identified similar barriers to effective education in informal and formal teaching by clinicians in hospitals³⁹. There is, however, no 'educational panacea'¹⁶. An increase in the effectiveness of continuing professional development can be created by establishing a process and a culture rather than specifying particular events, educational experiences or types of education. However, new approaches that focus on the process of education and the context in which it occurs should be developed. That focus should not be on specific events or educational interventions in a professional life. Educators in palliative

care need to address improvements in the quality of the process and make education more relevant to individual needs and interests, service needs and the needs of the team, however that may be defined.

Modern medicine provides opportunities and challenges in areas of care never before encountered and as such, educational activity must address moral and ethical issues facing doctors in their everyday practice. This is particularly relevant in care at the end of life. In general, medicine, and therefore medical education have been guided predominantly by principle-based ethical frameworks – the application of the principles of autonomy, beneficence, non-maleficence and justice to individual cases. This framework enables the development of guidelines and standards against which individuals, institutions and society can measure their actions. However, in the care of people who are dying, a broader dimension of that framework encompassing virtues and virtue-based ethics is needed. Virtues that arise from a caring bond and the public's expectation of a commitment to care are such fundamentals as trust, hope, compassion, courage and fidelity. Education in end-of-life care should acknowledge the significance of these virtues in medical care at the end of life⁴⁰. Palliative care must be based on a philosophy that acknowledges the inherent worth and dignity of each person. People who are dying have lost so many elements of their being it is essential that they can maintain trust in their medical attendants – messages that need to be reinforced throughout palliative care education.

Undergraduate education

Generally, on entering a medical school, a medical student expects to find an environment with a large workload, many subjects and much new terminology. In order to cope, students adopt learning strategies that will enable them to succeed (mainly in the

assessment hurdles). Staff will say their teaching is directed at helping the students to understand the subject matter - students will say that they adopt approaches to learning which favour reproduction of factual material that they think the staff will want to hear. Developments have taken place however to provide a more learner-centred approach (McMaster University in Canada, Maastricht in Holland, Newcastle in Australia for example) and problem-based learning has been developed in the area of medical education. The apparent success of these courses and the apparent difficulties encountered by many medical students in the UK encouraged the General Medical Council⁴¹ to review undergraduate education in Britain. The goal of a medical undergraduate programme is for the participants to achieve professional competence and to be safe and competent doctors. The curriculum provides the mechanism whereby this is achieved and much is written about the variations and developments that have evolved in that curriculum over the last three decades. Variations in the duration of medical undergraduate courses exist between universities within countries and around the world. When learning about death and dying the time allocated is no less variable. In the UK, for example, the time devoted to death and dying in the curriculum varies from a few hours to two weeks. There are, however, new developments in the inclusion of palliative care into a problem-based curriculum that promise opportunities for both vertical and horizontal integration⁴². Similar opportunities are arising in the New Zealand schools.

The sequence of learning has attracted interest too. The order in which subjects are presented implies that completion or mastery of those subjects is required for success in later subjects. Unfortunately there is little evidence to support this view. Much of what happens is possibly educational habit or custom and in fact in those schools that have developed problem-based approaches to learning this 'theory' has been dismissed.

Mastery of a particular subject means achieving a degree of success at a predetermined educational objective. It implies an objectives-based approach (a listing of components to be learned) and the competency levels must be worked out in advance. Frequent assessment of learning is needed and becomes an essential component of the programme. Over the years since that view was first proposed it has become evident that much is at fault with medical education. Colin Coles, in a summary of some aspects of medical education⁴³, has pointed out that students are feeling overloaded by what they have to learn. They fail to see the relevance of much that they need to learn, they quickly forget what they learn for examinations and they fail to retrieve what they have previously learned. The Kings Fund report⁴⁴ suggests that students should not have to learn huge quantities of information but should be given opportunities for discussion and reflection. Courses should be based on the needs of the learners and those learners should be encouraged to take responsibility for their own learning. The General Medical Council in the UK proposed that courses should help students to develop an attitude to learning based on curiosity and exploration of knowledge rather than its passive acquisition and that there should be a reduction in the excessive burden of information in the current course⁴¹.

The literature on medical student learning is often broad in its outlook and dependent on the philosophical standpoint of the researcher for its focus. A comprehensive overview of learning theory in medical education⁴⁵ emphasised the dichotomy of thought that existed between North America and Europe. The North American approach has been influenced by mainstream cognitive psychology and concentrates on basic learning processes and individual characteristics. The European perspective derives from attempts to explain the differences observed in how students approach a learning task and how these affect learning. That overview reviews approaches to learning and focus is drawn on the deep and

superficial approaches identified in Gothenburg by Marton and his colleagues⁴⁶. Deep learning is identified as an approach whose fundamental task is to understand the material or subject and tends to be associated with independent study. The surface approach is thought to be characterised by rote learning. A strategic approach is thought to be employed by those more interested in the context than by the nature of the task itself. A failure to interest students in the subject matter or to convince them of its vocational relevance is likely to encourage the use of surface or strategic approaches rather than the more desirable deep versatile approach. A further strategy has been added to this group; that of elaborated learning⁴⁷. A group of learners, termed elaborators, who could see an interrelationship between the different subjects they were learning has been identified. Elaboration occurs *'not because of the way the courses were arranged or taught, nor because of particular clinical attachments students attended, but because of the timing of an examination and the effect this has on students' approach to their revision'*(p21). Medical educators should therefore consider more seriously the relationship between the information being taught and students' ability at the time to process it effectively, and especially the role in this of actual clinical experience. This assertion implies that teachers of palliative care should pay more heed to the learners' previous experience, for example of loss and grief, when developing and modifying programmes.

Postgraduate and continuing education

Despite this apparent interest in the process of medical learning there have been many criticisms of the way in which the doctors of the future are educated. Deficiencies at all levels and in many areas have been identified⁴⁸⁻⁵⁴. These have been variously identified as over-work, bullying, emotional and physical stress and a lack of opportunity to learn. Despite these deficiencies, or perhaps even because of them, doctors do progress in their

training and studies have been undertaken to identify learning styles and approaches within that further education. Variance has been identified in the approaches of different groups of learners at different stages in their career^{45, 55-57}. Differences between specialist and non-specialist learners have been demonstrated⁵⁵. In the field of general practice, trainees have identified themselves as competent and successful learners and problem-solvers for whom learning is strongly related to personal achievement and improvement⁵⁷. Trainees in general practice showed a strong desire to continue learning and they displayed positive recognition that such continued learning should be seen as self-directed and therefore a personal responsibility. This ability to make or set goals makes self-directed learning a natural or inherent process. The value of any professional practice is underpinned by a motivation to learn and the development of self-direction in learning – that is, an inherent desire to explore the nature of that professional practice.

Schön¹⁵ described professionals' self-directed learning as an interaction with the environment in a reflective process that he calls 'reflection in action'. In this process the learner becomes aware of a learning need when a 'surprise' is encountered (also described as a discrepancy) through a process called 'knowing in action'. This process is thought to be the embedded knowledge that influences most of the activities of the physician⁵⁸. Schön makes the point that it is not possible for a professional to work effectively if they do not have this embedded knowledge. In effect, knowing in action represents those activities that are routine and automatic - so deeply learned that they require little reflection or effort. An example of this is the recognition of a diagnosis of a commonly seen problem. This level of practice is based on fact and science. The development of programmes in palliative care that focus on those certainties are attractive for this simplistic reason – the accumulation of facts about symptom management for example, is a relatively factual exercise. The

development of new problems or doubtful diagnoses produces 'surprises'. When a surprise occurs the physician is caused to pause and reflect on what has happened and on previous actions. This process of reflection may lead to the selection of a solution. This process takes place during the patient - physician interaction and may then produce an appropriate response during that interaction. The next stage of Schön's model is the 'experiment'. These experiments reflect the ability of the physician to reconstruct the information, knowledge and skills needed to accommodate what it was that was unusual about that encounter. The outcome of that action may then produce the opportunity for 'reflection on action'. New learning is then incorporated into the new body of knowledge and becomes part of the new knowing in action. This then is the closing of a loop that brings learning from previous experiences to bear on general procedures and develops new frames of reference for future problems. It is believed that this is one way in which physicians navigate through the maze of conflict, difference and uniqueness that characterises much of medicine.

Professional, social and personal forces interact to stimulate learning and change¹⁷. These personal forces, such as well being, can be mixed with either professional or social forces or can be employed on their own. Other stimuli to be identified⁵⁹ are the cultural (cultural meaning, expectations and norms) and the individual (which carries all the individual's past experience, growth and cultural interactions). The continuous interaction of these two strands produces a change in performance.

All these theories require certain characteristics within individuals in order that they can be effectively motivated to learn. Learners will all have the ability for forethought (the ability to perceive a desired outcome). They will all have the ability to set goals and visualise

future outcomes. There must be a perceived gap or need for learning and there must be the view of the individual to be able to undertake a particular task. An ability to recall previous success in self-directed learning is important - previous success is often a powerful motivator.

One of the central tenets of professional development is that it results in enhanced performance. The most relevant work is again that of Schön who uses experience as the critical piece of performance to understand how a professional's knowledge changes with reflective practice⁶⁰. Professionals develop a specific knowledge base to formulate and generate their professional work. Experience allows that knowledge base to expand in ways that cannot be readily linked to traditional teaching methods. Reflective practice proposes that problems are often not clear or well defined and it is those intermediate steps that help in clarification of problems and the development of solutions or new strategies for action. Schön also talks of the 'right kind of telling' that takes place when students work closely with their teacher to learn how to frame the questions and to respond in an appropriate manner.

Developing new approaches

The improvement in end-of-life education has been addressed in differing ways in different countries. In the United Kingdom, the Association for Palliative Medicine produced a palliative medicine curriculum in 1991⁶¹ and the Canadians have also identified a palliative care curriculum⁶². The United States followed in 1994 when the American Board of Internal Medicine and the American Academy of Hospice and Palliative Medicine identified core competencies and developed core curricula and training manuals for house officers, students and physicians in practice⁶³.

Having moved to New Zealand in 1994, I had the opportunity to address some of the relevant issues for undergraduate palliative care education. Earlier work^{10,11} showed a paucity of time and subject matter in the undergraduate curriculum that was relevant to care at the end of life. A small group of doctors from the Australia and New Zealand Society for Palliative Medicine wrote an undergraduate medical palliative care curriculum⁶⁴ that has received endorsement from all the Deans of medical schools in Australia and New Zealand. Building on some of the aspects contained in that document enabled the development of a broader and more effective approach to undergraduate education in palliative care⁶⁵. That approach was informed by an understanding that learning is integrally related to the solution and understanding of real life problems. Learning is encouraged by the fostering of reflection both in and on action. For many students death and dying seem far removed from their everyday life and work but by acknowledging their past experiences and knowledge and creating a realistic context for learning we hoped to influence the effectiveness, nature and outcomes of their learning. Using reflective practices, role-modelling and feedback on action we examined and modify attitudes and beliefs when necessary and appropriate. By encouraging reflection we attempt to help them develop lifelong, self-directed learning in this aspect of their practice. Continuing work builds on those experiences. Students develop a more reflective approach to talking and listening to people who are dying – they are able to identify the salient issues not only for the patient and family but become increasingly confident in identifying what *personal* issues are raised by such encounters. Following groups of students through their clinical careers will show whether or not this reflective approach is maintained.

Care in the context of medicine

The lack of understanding and adequate conceptualisation of care¹⁰ challenges educators to develop programmes relevant to learners in this area. Much of health professionals' understanding about care draws predominantly on contributions from nursing to our understanding of caring as a discrete entity. By addressing some of the issues around medical socialisation combined with aspects of undergraduate medical education some of the areas of difficulty in doctors' learning to care have been identified⁶⁶. An interpretive phenomenological study of how doctors learn to care for people who are dying⁶⁷ demonstrated that formal undergraduate and postgraduate education had not prepared the doctors in that study for end-of-life care. Those doctors testified most powerfully that they learned about the care of dying people, in an emotional and intimate way from those dying people. Further development of journaling, portfolio work and reflective practice will ensure more effective elaborated learning in this area. Analysis of data⁶⁷ suggests that the concept of learning to care is not influenced by anything specific that happens in the current undergraduate curriculum – more, it is heavily influenced by personal experiential learning.

Literature supports the view that learning through experience should not be conceived in terms of outcomes (and in this case this means what has been learned, how well it has been learned and what grade or mark it merits). Rather it should be conceived in terms of a continuous process, which is grounded in experience. Despite the recognition of palliative medicine as a discrete specialty, evidence still exists that in many cases current training is inadequate, most strikingly in the clinical years at medical school⁶⁸. There is limited evidence of improvement in the care of cancer patients and a dearth of evidence concerning patients dying from other, more common causes⁶⁹.

In the past, medical education has focussed on the thinking (symbolically- oriented) and doing (behaviourally-oriented) learning environments⁷⁰ largely ignoring the feeling (affectively-oriented) and watching (perceptually-oriented) environments. Changing the focus from cure to care is a challenging task for medical teachers. They have concentrated for decades on the acquisition of facts (structured knowledge) but are now encouraged to acknowledge that professional learning consists of two dimensions. The structured knowledge and reflections on this knowledge within a given situation and ideas, exchanges, events and examples brought to the situation for subsequent reflection, the professional 'inner voice' or 'art'¹⁵. Practice reveals a 'kind of knowing' which does not stem from prior individual knowledge. The more appropriate approach to learning about care at the end of life is one which consists of a search for underlying meaning and structure leading to superior performance⁷⁰. Learning in this way requires a task that is personally involving (as the care of someone who is dying should be) and leads to reading and understanding of the issues highlighted by such a task. Experiential learning bridges learner's existing levels of understanding and philosophies with a new set of knowledge, abilities and beliefs. It involves learners in adopting a more assertive role and also requires a transfer of learning from an academic mode to one that involves a more practical and personal content⁷¹. None of these items is readily incorporated into 'classical' medical education where education has been predominantly teacher-centred and didactic.

Even a hundred years ago Sir William Osler, one of the greatest teachers medicine has ever seen, was encouraging other teachers to view medical education differently.

'The hardest conviction to get into the mind of the beginner is that the education upon which he is engaged is not a college course, not a medical course but a life course, for which the work of a few years under a teacher is but a preparation'.

*'The more hurtful thing the practitioner can do is fail to realise, first, the need for a lifelong progressive personal training and secondly, the danger lest, in the stress of practice, he sacrifice the most precious of all possessions, his mental independence.'*⁷²

Recent results from a phenomenological study of medical students' experiences of spending time with people who are dying confirms that those students often learn about the care of people from those people themselves⁷³. Students in their first clinical year were asked to write a personal reflection on their experience with people approaching death as part of an assignment during their general practice attachment. The essence of these reflections is interpreted as being embedded in five key themes that contributed to the structure of the experience for them. The encounters differed from what the medical students had anticipated; students identified an emotional component to the experience; they explored their own and the patient's understandings of spirituality; they reflected on personal meanings of the encounter and they suggested ways in which they may learn to care for people who are dying more effectively. The way in which those students approached end of life care was altered through a transformative educational experience that encouraged them to draw on their own experiences and skills. The study is planned to continue through their clinical undergraduate years and beyond in order to identify if these changes are maintained and built on.

Conclusion

Through this exploration and development of thinking a significant contribution to understanding about medical teaching and learning is being made in this most essential of educational activities. These documents represent a personal journey through differing stages of understanding about teaching and learning in palliative care. From the initial work⁷ on determining educational needs and learning preferences through qualitative examination of how doctors learn to care for people who are dying⁶⁷, to continuing work with undergraduate medical students⁷³, I have demonstrated developments in approaches to end-of-life education that have challenged some of the more 'classical' aspects of medical education. Too often, medical teaching focuses on disease and technical approaches at the expense of a broader understanding of the impact of a life threatening disease on a patient and family. There is still a pervasive view that death represents medical failure and that physicians should not express personal emotions. This collection of work shows that students and physicians do identify very clearly with personal issues and that they would favour recognition, validation and discussion of their emotions when caring for dying people. Self-knowledge and self-reflection are now recommended as core competencies in end-of-life education in some countries⁷⁴.

My own clinical experience supports the view that achieving deep understanding and close connection with people who are dying provides rich rewards. Intimate relationships are professionally rewarding and illuminating⁶⁷. Concentrating on medical process (as much of disease management is) rather than on likely outcomes encourages clinicians to hide behind a 'medical cloak' when what many people who are dying need is empathy, intimacy and understanding.

These papers promote an increase in understanding of what it means to teach and learn about care for someone at the end of life. They represent a clarification and repositioning of key components of the process of education that is necessary for the development, not just of palliative physicians but also of doctors entering any specialty where people will die.

They also promote an understanding and acceptance of the importance of providing effective, empathetic and humanistic care for people at the end of life.

Palliative medicine is a young specialty that will grow and develop as the need for a greater understanding and expertise in this area is realised. This work contributes substantially to knowledge in this area and has been influential in that growth and development. By emphasizing that learning does not merely need to take place in the science but also in the art of palliative care, it encourages a shift in educational emphasis.

References

1. Weatherall, D.J. : 1993: Introduction, in Lowry, S. Medical education. London: BMJ Publishing Group.
2. James, N., Field, D. : 1992: The routinization of hospice: charisma and bureaucratization. Social Science & Medicine 34:12, 1363-1375.
3. Department of Health and Social Security, Wilkes, E. (ed) : 1987: Health services development: Terminal care. Heywood, Lancashire: Health Publications Unit (HL/87/4 and LAC/87/4/2).
4. Finlay, I.G., Stott, N.C.H., Marsh, H.M. : 1993: Distance learning in palliative medicine. European Journal of Cancer Care 3, 163-168.
5. MacLeod, R.D. : 1992: Teaching postgraduate palliative medicine (unpublished Masters thesis) University of Dundee, Scotland.
6. **MacLeod, R.D., Nash, A. : 1991: Teaching Palliative Care in General Practice - A Survey of Education Needs and Preferences. Journal of Palliative Care 7:4, 9-12.**
7. Merriam, S.B., Caffarella, R.S. : 1991: Learning in adulthood: a comprehensive guide. San Francisco (CA): Jossey-Bass.

8. Knowles, M.S. : 1980 : The Modern Practice of Adult Education. New York, Cambridge.

9. MacLeod, R.D., Nash, A. : 1992: "Taking the Lid Off" - Observations of the Process of Palliative Care Education for General Practitioners. Postgraduate Education for General Practice 3, 28-33.

10. James, C., MacLeod, R.D. : 1993: The Problematic Nature of Education in Palliative Care. Journal of Palliative Care 9:4 , 5-10.

11. MacLeod, R.D. : 1993: Education in Palliative Medicine : A Review. Journal of Cancer Education 8:4, 309-312.

12. MacLeod, R.D., Nash, A. : 1994: Multidisciplinary Palliative Care Education. Journal of Interprofessional Care 8:3, 283-288.

13. Bandura, A. : 1986: Social foundations of thought and action: a social cognitive theory. Englewood Cliffs (NJ): Prentice-Hall Inc.

14. MacLeod, R.D., Nash, A. and Charny, M. : 1994: Evaluating Education in Palliative Medicine. European Journal of Cancer Care 3, 163-168.

15. Schön, D.A. : 1993: The reflective practitioner: how professionals think in action. New York: Basic Books.

16. Grant, J., Stanton, F. : 2000: The effectiveness of continuing professional development. Edinburgh: Association for the Study of Medical Education.
17. Fox, R.D., Mazmanian, P.E., Putnam, R.W. : 1989: Changing and learning in the lives of physicians. New York: Praeger.
18. MacLeod, R.D. : 1992: Symptom Control in Palliative Medicine and Terminal Care in, Rowe, M. (ed.). BDHA Clinical Standards. Bath: BDHA.
19. MacLeod, R.D., Vella-Brincat, J. : 1994: The Palliative Care Handbook, Bath, England: Dorothy House Foundation.
20. Vella-Brincat, J., MacLeod, R.D. : 1995: Symptom Control: Depression, insomnia and confusion. Pharmaceutical Journal 254, 754-756.
21. MacLeod, R.D. : 1994: Use of Bisphosphonates in Malignant Disease. Network 3, 14: Wellington: Cancer Society of New Zealand.
22. MacLeod, R.D. : 1994: Medical decisions at the end of life. New Zealand Medical Journal 107, 253.
23. MacLeod, R.D. : 1995: Palliative care in cancer patients. New Ethical Disease Index 25-28.
24. MacLeod, R.D. : 1995: Palliative Care (editorial). New Ethical 32:7, 11.

25. MacLeod, R.D. : 1995: Managing physical symptoms (other than pain). New Ethicals 32:7,13-18.
26. MacLeod, R.D. : 1995: Intestinal Obstruction in Palliative Care in New Zealand. Auckland (NZ): Douglas.
27. MacLeod, R.D., Vella-Brincat, J. : 1996: The Palliative Care Handbook. Auckland (NZ): Ciba-Geigy.
28. MacLeod, R.D. : 1997: Advance directives. New Zealand Family Physician 24:3: 25.
29. MacLeod, R.D. : 1998: Palliative Care (towards 2000). New Ethicals Journal 1:1, 32.
30. MacLeod, R.D. : 1998: Palliative Care. New Ethicals Journal 1:5, 20-21.
31. MacLeod, R.D. : 1998: Nausea and Vomiting in Palliative Care. New Ethicals Journal 1:6, 41-46.
32. Royle, D., MacLeod, R.D. : 1999: Management of constipation in palliative care. New Ethicals Journal 2:6, 55-59.

33. Royle, D., MacLeod, R.D. : 1999: Management of malignant bone pain. New Ethicals Journal 2:11, 23-29.

34. MacLeod, R.D.: 2000: Respiratory symptoms in palliative care. New Ethicals Journal 3:1, 61-64.

35. MacLeod, R.D., Vella-Brincat, J. : 2000: The Palliative Care Handbook. Auckland: Novartis.

36. **MacLeod, R.D. : 1997: "Teaching holism in palliative care and hospice".**
American Journal of Hospice & Palliative Care 14:1, 12-16.

37. Boud, D.J., Keogh, R., Walker, D. (eds) : 1985: Reflection: turning experience into learning. London: Kogan Page.

38. **MacLeod, R.D., James, C.R. : 1997: Improving the Effectiveness of Palliative Care Education. Palliative Medicine 11:5, 375-380.**

39. Weissman, D.E., Block, S.D., Blank, L. *et al* : 1999: Recommendations for incorporating palliative care education into the acute care hospital setting.
Academic Medicine 74:8, 871-877.

40. MacLeod, R.D. : 1997: "All patients need doctors who care as well as cure". New Zealand Family Physician 24: 6, 7-9.

41. General Medical Council: 1991: Undergraduate Medical Education. Discussion document by the Working Party of the GMC Education Committee.
42. Lloyd-Jones, G., Ellershaw, J., Wilkinson, S., Bligh, J.G. : 1998: The use of multidisciplinary consensus groups in the planning of an integrated problem-based curriculum. Medical Education 32, 278-282.
43. Coles, C. : 1990: Elaborated learning in undergraduate medical education. Medical Education 24, 14-22.
44. Towle, A.: 1991: Critical Thinking: the Future of Undergraduate Medical Education. London: King's Fund.
45. Newble, D.I., Entwistle, N.J.: 1986: Learning styles and approaches: implications for medical education. Medical Education 20, 162-175.
46. Marton, F., Saljo, R.: 1984: Approaches to learning in: Marton, F *et al* (eds) The experience of learning. Edinburgh: Scottish Academic Press.
47. Coles, C.: 1990: Elaborated learning in undergraduate medical education. Medical Education 24, 14-22.
48. Firth-Cozens, J.: 1987: Emotional distress in junior house officers. British Medical Journal 295: 533-6.

49. Firth-Cozens, J.: 1990: Sources of stress in women junior house officers. British Medical Journal 301: 89-91.
50. Dent, T.H.S., Gillard, J.H., Aarons, E.J., Crimlisk, H.L., Smyth-Pigott, P.J.: 1990: Preregistration house officers in the four Thames regions: 1. Survey of education and workload. British Medical Journal 300: 713-6.
51. Dent, T.H.S., Gillard, J.H., Aarons, E.J., Crimlisk, H.L., Smyth-Pigott, P.J.: 1990: Preregistration house officers in the four Thames regions: 2. Comparison of education and workload in teaching and non-teaching hospitals. British Medical Journal 300:716-8.
52. Collier, J.: 1989: Medical education as abuse. British Medical Journal 299:1408-9.
53. Fraser, R.C.: 1991: Undergraduate medical education: present state and future needs. British Medical Journal 303: 41-3.
54. Roberts, J.: 1991: Junior doctors' years: training not education. British Medical Journal 302: 225-8.
55. Newble, D.I., Hejka, E.J., Whelan, G.: 1990: The approaches to learning of specialist physicians. Medical Education 24: 101-9.
56. Emilia, O., Mulholland, H.: 1991: Approaches to learning of students in an Indonesian medical school. Medical Education 25: 462-470.

57. Bligh, J.G.: 1992: Independent learning among general practice trainees: an initial survey. Medical Education 26: 497-502.

58. Fox, R.D.: 1991: New research agendas for CME: organising principles for the study of self directed curricula for change. Journal of Continuing Education for Health Professionals 11:155-167.

59. Nowlen, P.M.: 1988: A new approach to continuing education for business and the professions. New York: MacMillan.

60. Schön, D.A.: 1987: Educating the reflective practitioner. San Francisco: Jossey-Bass.

61. Association for Palliative Medicine of Great Britain and Ireland. :1991 : Palliative Medicine Curriculum. Southampton: APMGBI.

62. MacDonald, N., Mount, B., Scott, J., and Boston, W. : 1993: The Canadian Palliative Care Curriculum. Journal of Cancer Education 8: 3, 197-201.

63. American Board of Internal Medicine : 1994: Caring for the dying: identification and promotion of physician competency. Philadelphia: American Board of Internal Medicine.

64. Ashby, M., Brooksbank, M., Dunne, P., MacLeod, R.D. : 1997: Australasian Undergraduate Medical Palliative Care Curriculum. Melbourne: ANZSPM.

65. MacLeod, R.D., Robertson, G. : 1999: Teaching about living and dying: medical undergraduate palliative care education in Wellington, New Zealand. Education for Health 12:2, 185-192.
66. MacLeod, R.D. : 2000: Learning to care: a medical perspective. Palliative Medicine 14:3, 209-216.
67. MacLeod, R.D. :2001: On reflection: how doctors' learn to care for people who are dying. Social Science & Medicine 52, 1719-1727
68. Billings, J.A., Block, S. : 1997: Palliative care in undergraduate medical education. Journal of the American Medical Association 278: 9, 733-738.
69. Fordham, S., Dowrick, C. : 1999: Is care of the dying improving? The contribution of specialist and non-specialist to palliative care. Family Practice 16: 6, 573-579.
70. Kolb, D. : 1984: Experiential learning: Experience as the source of learning and development. Englewood Cliffs (NJ): Prentice Hall.
71. Eley, M. : 1992: Differential adoption of study approaches within individual students. Higher Education 23, 231-254.
72. Osler, W. : 1906: Aequanimitas and other addresses to medical students, nurses and practitioners of medicine (2nd edition) Philadelphia: Blakiston.

73. MacLeod, R.D., Parkin, C., Pullon, S., Robertson, G. : 2001: Early clinical exposure to people who are dying: turning points in learning to care at the end of life. Social Science & Medicine (submitted for publication)
74. Barnard, D., Quill, T., Hafferty, F. W. *et al.* : 1999: Preparing the ground: contribution of the pre-clinical years to medical education for care near the end of life. Academic Medicine 74: 5, 499-505.

Published articles for inclusion in thesis by publication for the degree of Doctor of Philosophy at the University of Glamorgan/Prifysgol Morgannwg

1. MacLeod, R.D., Nash, A.: 1991 : Teaching palliative care in General Practice - a survey of education needs and preferences: Journal of Palliative Care : 7 : 4 : 9-12 (RDM 70% - AN 30%)
2. MacLeod, R.D., Nash, A.: 1992 : "Taking the lid off" - observations of the process of palliative care education for General Practitioners: Postgraduate Education for General Practice : 3 : 28-3 (RDM 60% - AN 40%)
3. James, C., and MacLeod, R.D.: 1993 : The problematic nature of palliative care education: Journal of Palliative Care : 9 : 4 : 5-10 (RDM 60% - CRJ – 40%)
4. MacLeod, R.D.: 1993 : Education in palliative medicine : a review: Journal of Cancer Education 8: 4: 309-312
5. MacLeod, R.D., Nash, A.: 1994 : Multidisciplinary palliative care education: Journal of Interprofessional Care 8:3: 283-288 (RDM 70% - AN 30%)
6. MacLeod, R.D., Nash, A. and Charny, M.: 1994 : Evaluating education in palliative medicine : European Journal of Cancer Care : 3: 163-168 (RDM 60% - AN 30% - MC – 10%)
7. MacLeod, R.D.: 1997 : Teaching holism in palliative care and hospice American Journal of Hospice & Palliative Care Jan/Feb, 12-16
8. MacLeod, R.D., James, C.R.: 1997 : Improving the effectiveness of palliative care education Palliative Medicine 11, 5, 375-380 (RDM 60% - CRJ 40%)
9. MacLeod, R.D., Robertson, G.: 1999: Teaching about living and dying Education for Health 12:2; 185-192 (RDM 80% - GR 20%)
10. MacLeod, R.D.: 2000 : Learning to care: a medical perspective Palliative Medicine 14:3, 209-216
11. MacLeod, R.D.: 2001 : On reflection: how doctors' learn to care for people who are dying Social Science & Medicine 52, 1719-1727

5th October 1999

To whom it may concern,

This is to confirm that the published research papers detailed below were the result of joint work by the authors. Where Dr MacLeod's name appears first in the listing, his contribution was more than 50%. For listings 1 and 3, Dr MacLeod's contribution was significantly more than 50%.

1. MacLeod, R.D., Nash, A. : 1991 : Teaching Palliative Care in General Practice - A Survey of Educational Needs and Preferences : Journal of Palliative Care : 7 : 4 : 9-12
2. MacLeod, R.D., Nash, A. : 1992 : "Taking the Lid Off" - Observations of the Process of Palliative Care Education for General Practitioners : Postgraduate Education for General Practice : 3 : 28-33
3. MacLeod, R.D., Nash, A. : 1994 : Multidisciplinary education in palliative care : Journal of Interprofessional Care : 8 : 3 : 283-288
4. MacLeod, R.D., Nash, A. : 1994 : Evaluating palliative care education : European Journal of Cancer Care : 3 : 163-168

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1st October, 2001

To whom it may concern

This letter is to confirm that the percentage contribution of Professor Chris James and Dr Rod MacLeod to the papers listed in his submission for PhD by Publication is as follows.

James, C. R. and MacLeod, R. (1993) The problematic nature of education in palliative care. *Journal of Palliative Care*, 9:4, 5-10. (RDM 60%, CRJ 40%)

MacLeod, R. and James, C.R. (1997) Improving the effectiveness of palliative care education. *Palliative Medicine*, 11:5, 375-380. (RDM 60%, CRJ 40%)

Yours sincerely




Chris James
(Professor of Educational Management)

12 December 2000

To whom it may concern,

This is to confirm that the published research paper identified below was the result of joint work by the authors. Dr MacLeod contributed 80% of this publication.

MacLeod, R.D., Robertson, G. : 1999 : Teaching about Living and Dying: Medical Undergraduate Palliative Care Education in Wellington, New Zealand : Education for Health : 12 ; 2 ; 185-192.



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Teaching Palliative Care in General Practice: A Survey of Educational Needs and Preferences

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Abstract / We surveyed general practitioners in the Bath District Health Authority to determine their educational needs in palliative care and their preferred methods of learning, in order to develop an appropriate education program. The survey confirmed our ideas as to the content of the program. There was support for our hypothesis that the majority would favor didactic approaches and would feel generally uncomfortable with experiential methods. The issue of professionals' needs in stressful situations proved to be a surprisingly strong one.

Résumé / Le but de cette enquête était d'identifier les caractéristiques des médecins de famille desservant un district d'environ 405,000 habitants. Notre objectif était de connaître leurs besoins de formation en matière de soins palliatifs, la méthode d'enseignement préférée, et ce afin d'élaborer un programme qui répondrait à ces besoins. Notre enquête n'a fait que confirmer ce que nous doutions déjà quant au contenu du programme, cependant nous n'avions pas prévu que les professionnels soulèveraient leurs besoins d'aide en situation de stress. Notre étude a aussi confirmé que la majorité souhaitait une approche didactique et qu'ils se sentaient mal à l'aise avec toute méthode expérimentale. Ces résultats démontrent que nous devons développer ce programme selon l'approche que nous avons prévue, tout en respectant le besoin que les répondants ont exprimé de soutien dans les situations de stress. Il nous apparaît également que nous devons être très prudents lors de l'utilisation de méthode expérimentale d'enseignement.

REVIEW

Since the report of the Department of Health and Social Services Working Group (1) there has unfortunately been only a slow increase in the teaching of terminal care to medical students. By implication, therefore, there are still many medical graduates without adequate training in palliative medicine.

There have been exceptions, and great progress has been made in some centres. Stout and Irwin (2) first outlined the development of an integrated approach to medical education, and Irwin (3) later went on to describe the develop-

ment of a teaching program at Queen's University, Belfast that included a course for medical students with a multidisciplinary focus (4). With other authors he has examined the communication skills training (5) and the formal teaching of medical ethics (6) in the same course.

Attempts at evaluating programs aimed at improving skills have been few, but some have been carried out (7). It may be that the paucity of information is reflected in the development of courses without pre-specified communication objectives, or merely that the evaluation has not been undertaken. It has been argued by Tabar that set objectives are crucial for evaluation and that evaluation in turn is crucial for effective teaching (8).

Recent work by Oliver (9) has investigated the training and knowledge of clinical skills and symptom control in medical students, house officers, and trainees in general practice. We do know that dealing with death and dying is a major source of stress for junior doctors (10), but we do not sponsor any attempt to combine training in palliative medicine with the search for adequate coping mechanisms.

Field and Howells (11) have looked at the attitudes toward dealing with dying patients reported by medical students, but we know of no similar work at the postgraduate level.

METHODOLOGY

There are 216 principals in general practice in the Bath Health District, and it is hoped to be able to offer an education program which will attract them. In order to find out what their specific needs and preferences are, a questionnaire format was chosen. Questionnaires, with addressed reply envelopes, were sent via internal post to the 216 physicians, requesting a reply date 14 days ahead.

The first part of the questionnaire asked for demographic data, including years since qualification, list of qualifications obtained, non-medical degrees, and whether the principal had completed a vocational training scheme for General Practice.

The second part of the questionnaire was aimed at identifying the content requirements of

an education program in palliative medicine. Variety was ensured by asking questions which required yes/no answers, answers on a scale from 'Strongly Agree', through 'Agree', 'Disagree', to 'Strongly Disagree', with 'Don't Know' added, and questions which asked opinions about who or what should form the basis of particular sessions.

The third part of the questionnaire addressed the individual's feelings and wishes about learning and offered a variety of ways of answering the questions as before.

Space was left for comment and further comment was invited if desired. The questionnaire covered three pages, but sufficient space was left between questions for additional comments, and this was felt to balance the apparent length of the whole.

RESULTS

Respondents. Of the 216 GP principals contacted, 155 (72%) replied. The postgraduate qualifications of this group are shown in Table 1.

Table 1 / POSTGRADUATE QUALIFICATIONS OF GP RESPONDENTS

Affiliation	Number	Percent
Member of the Royal College of General Practitioners (MRCGP)	66	42.6%
Member of the Royal College of Physicians (MRCP)	12	7.7%
Member of the Royal College of Psychiatrists (MRCPsych)	2	1.3%
Fellow of the Royal College of Surgeons (FRCS)	2	1.3%
Fellow of the Royal College of General Practitioners (FRCGP)	1	0.6%
Member of the Royal College of Pathologists (MRCPsPath)	1	0.6%
Doctor of Medicine (MD)	1	0.6%
None of these	70	45.2%
Total	155	100%

A large majority (146) of the respondents worked in partnership with 2 or more others, while 47 (30%) worked in a practice of 6 or more (Table 2).

Table 2 / NUMBER OF PARTNERS IN PRACTICE

Number of Partners	Respondents	Percent
1	9	5.8%
2	10	6.5%
3-5	89	57.4%
6-12	47	30.3%
Total	155	100%

The years of medical practice since qualification are shown in Table 3.

Content. A little over half those who commented, 86 (55%), felt that the pathological basis of

Table 3 / YEARS SINCE QUALIFICATION

Years	Respondents	Percent
4-10	33	21%
11-20	74	48%
21-30	34	22%
31-40	14	9%
Total	155	100%

malignant disease should be included. Respondents were overwhelmingly in favor of radiotherapy, chemotherapy, and surgery in terminal care being included in the program (91%, 94%, and 82.5% respectively).

All the respondents felt that teaching about various aspects of pain control should be included, and a large majority (90%) felt that there was a need for the teaching of specific therapeutic techniques for symptoms other than pain.

There was a large positive response (94%–97%) to the inclusion of teaching about the psychosocial aspects of disease for each of these categories, including patient and family grief and patient and family fears.

A question about the amount of time spent teaching communication skills elicited a split between those who felt sufficient time is spent here (64=41%) and those who did not (66=43%).

An overwhelming majority (141 = 97%) felt it important to learn about personal coping mechanisms, but the respondents were divided about what this should involve. A significant proportion (44%) felt that formal psychotherapy could be included. The largest response was for the setting up of support groups (85%), while a large number also felt that co-counseling could be included (80%).

A majority (57.5%) felt that spiritual needs of patients and families should be addressed as a separate issue. A smaller number — less than half the respondents (49%) — felt that their own spirituality might appropriately be examined.

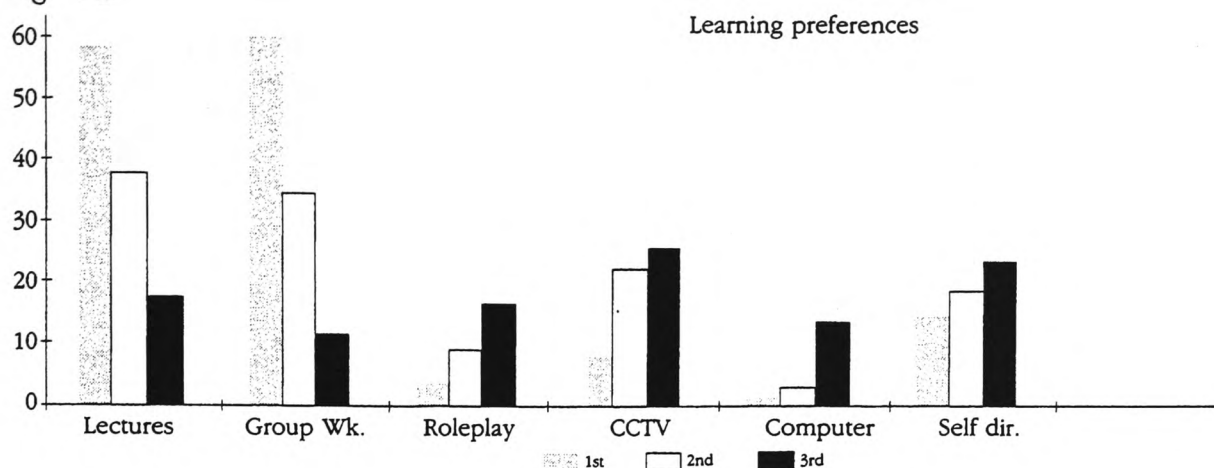
When questioned about who should teach about death and dying, there was a wide range of choices, and respondents variously identified oncologists, hospice doctors, Macmillan nurses, and GP trainers.

Learning Methods. In the final section on learning methods, lectures and group work came out as firm favorites. The relatively new method of videotaping with feedback gained support ahead of role playing and computer-assisted learning. Self-directed learning was encouragingly favored by a significant number of respondents and was only surpassed by lectures and group work (Figure 1).

DISCUSSION

The high response rate (72%) may indicate a high level of motivation and commitment to learning

Figure 1



more about palliative care on the part of GPs in the district.

The demographic information, while limited, may be valuable in its indication of the high number of respondents who work in large group practices and significant in the number of years since training. It may be suggested that those who trained many years ago continue to favor learning experiences familiar from those training days. There is evidence to suggest that training approaches have changed significantly in recent years, favoring more emphasis on small group work and role playing as learning methods.

There was much encouragement, in terms of positive responses, for the inclusion of factual information regarding disease processes and therapies, and this may reflect the respondents' expectations of such an educational program. It is our experience that the physical or disease-oriented aspects of palliative care are easily and quickly explored, and that the psychosocial aspects are those which demand more time and care in teaching.

Respondents seemed to be extremely aware of the needs of professional carers (themselves?) to have formal support in their coping with the stress of palliative medicine. The strength of opinion indicated by the 44% of respondents who answered "yes" to the question 'Could formal psychotherapy be included?', as a means of coping personally with stressful situations in palliative care, was surprising, however. This may indicate a depth and strength of a feeling of need which we did not anticipate and which has implications not only for the education program we offer, but for the seriousness with which we take our role in supporting colleagues.

It is generally accepted in the field of palliative care that it is impossible to care holistically for people facing death unless spiritual issues are addressed, and there is a general acceptance also that such exploration inevitably confronts our

own spiritual awareness, which may be found lacking in the face of the questions patients ask. It was not surprising, then, that such a large number of respondents indicated an awareness of the spiritual needs of dying patients, but interesting that so few accepted the implications for professional carers in this area.

It may be possible to speculate that such exploration may be uncomfortable and distressing for professional carers and may place them in the position of not only acknowledging such distress, but having to find ways in which to resolve it. With a view to the apparent lack of available support suggested by the answers to questions on psychosocial care, this exploration may be considered dangerous.

It was perhaps not surprising that the majority favored less active involvement in learning techniques. It was encouraging that 40% favored group work, and less encouraging that so many still favor the lecture format. There is a role for lectures, but we favor a style of teaching which actively includes participants, thereby acknowledging and using the knowledge and expertise they bring with them. The lecture implies a flow of knowledge and information from teacher to student which, we believe, is inappropriate in palliative care at this level.

Clear evidence is not available to correlate, in this study, any relationship between the age of the respondent with preferred learning styles.

We have encountered instances where role playing and the use of closed circuit TV take place with little consideration of the personal investment learners make in their participation.

The creation of a supportive atmosphere, with adequate ground rules and shared facilitation, should enable a level of safety in which participants can explore, through these media, experiences similar to those with which their patients cope. In this way, we believe, we may learn to

develop empathy with our patients and work more effectively to help them cope. Our experience suggests that, when role playing takes place within such supportive frameworks, and with consideration of the needs of individuals, it can provide an extremely important learning experience.

Limitations of the Questionnaire. The authors are aware of limitations in the questionnaire that need to be considered when interpreting results.

On reflection, the degree of comment between "strongly agree" and "agree" is difficult to interpret, and little use was made of this distinction. However, one comment of "strongly disagree" seemed important enough to justify the inclusion of this category. Also a format of "agree/disagree/don't know" seems very narrow, and may have elicited more need for comment.

The questions about personal approaches were placed in the third section so that the respondents would by then feel comfortable with the questions and, perhaps, be more likely to answer them.

There appears to be little evidence that respondents were inhibited by these questions, and it may have been possible to explore these important issues further.

We have had some discussion about whether the questionnaire should have asked for more personal information, in order to link it more closely with the responses about personal learning needs.

We realize that a more learner-centred approach within the questionnaire format might have allowed the development of issues which we did not anticipate or include.

The anonymity of the questionnaire did not seem to be relevant to some respondents, who happily signed their further comments.

CONCLUSION

Much support was indicated for the development of an education program in palliative care.

The research has indicated a high level of awareness of the need for learning in both physical and psychosocial areas.

The survey suggests the need, not only for education, but for support for those caring for dying patients and their families, and among respondents for an awareness of that need in themselves and in their colleagues.

The development of an education program which will attract GP principals should include those approaches to learning which they find acceptable, and the inclusion of more active, participatory methods may discourage many from attending. The introduction of such methods may be possible, but with care. Courses and work-

shops offered should be explicit in terms of teaching techniques, and our philosophy of education should be made available to potential participants.

It is our intention to build on the willingness indicated in the survey and to have participants work in small groups to develop problem-solving approaches to care, while remaining aware of some participants' reluctance and misgivings about the use of role playing.

We have developed a method of demonstrating role play situations which involves the participants in decision making but does not necessarily involve them directly in the playing of roles unless they wish to do so. This may be a useful next step in introducing professionals who have little or no experience of role playing to the possibilities of this more participatory approach to learning.

Note: Copies of the questionnaire may be obtained by writing to the authors.

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REFERENCES

1. Wilkes E, Chairman. Terminal Care: Report of a Working Group. Department of Health and Social Services. London: HMSO, 1980.
2. Stout RW, Irwin WG. Integrated medical student training. A combined course in community medicine, general practice, geriatric medicine and mental health. *Medical Education* 1982; 16:143-146.
3. Irwin WG. Teaching terminal care at Queen's University of Belfast, part I. Course, sessional objectives, and content. *Br Med J* 1984; 289: 1509-1511.
4. Irwin WG. Teaching terminal care at Queen's University of Belfast, part II. Teaching assessments and assessment of topic. *Br Med J* 1984; 289: 1604-1605.
5. Irwin WG, McClelland RS, Love AH. Communication skills training for medical students: an integrated approach. *Medical Education* 1989; 23: 387-394.
6. Irwin WG, McClelland RS, Stout RW, Stchedroff M. Multidisciplinary teaching in a local medical ethics course for clinical students. *J Med Ethics* 1988; 14: 125-128.
7. Anderson JL. Evaluation of a practical approach to teaching about communication with terminal cancer patients. *Medical Education* 1982; 16: 202-207.
8. Tabar H. Curriculum Development, Theory and Practice. New York: Harcourt, Brace and World, 1962.
9. Oliver D. Teaching in, and knowledge of, terminal care in medical studies and junior doctors. *Palliative Medicine* 1989; 3: 293-297.
10. Firth-Cozens J. Emotional distress in junior house officers. *Br Med J* 1987; 295: 533-535.
11. Field D, Howells K. Dealing with dying patients: difficulties and strategies in final year medical students. *Death Studies* 1988; 12: 9-2.

Taking the lid off: observations on the process of palliative care education for general practitioners

ROD MACLEOD and ANN NASH

Introduction

The recent appointment of a physician to the Bath Hospice, with a remit to develop a medical education programme alongside the Macmillan Education Centre, provided an opportunity to consider the type of education required by general practitioners.

The Centre already has a well developed programme in palliative care, aimed at a multi-disciplinary group of professionals, addressing both broad and specific issues within the speciality.

This paper describes the philosophy of our educational approach and the programme which was developed for GP principals and trainees. We use small group work to explore the personal and professional problems encountered when caring for dying patients and grieving relatives. The success or failure of the teaching methods employed is discussed and an attempt is made to evaluate their effect on the group.

Philosophy

Our research into the perceived educational wishes and needs of local GPs (MacLeod and Nash, 1991) suggested a preference for factual input, delivered in a didactic fashion. This presented some problems for the authors, who are committed to an individually orientated, experiential and facilitated approach to adult learning. The philosophy of the Education Centre is based on an acknowledgement that course members bring with them much knowledge and experience of palliative care; facilitation of their learning must include using that knowledge and experience, and adding where necessary from our own resources. We aim to provide a learning environment where all contribute and where all contributions are valued.

We believe that palliative care is enhanced by the caring individual's awareness of his/her own mortality and experience of personal loss.

Facilitation and content

We were aware from our research that GPs would probably be uncomfortable with a highly experiential approach, and that they would expect some degree of didactic

factual input. We decided, therefore, to offer a short course which would contain some didactic sessions, but also include experiential techniques which would allow individuals to become involved as far as they felt able. We felt it important to pursue a problem-orientated approach and to employ a problem-solving framework (Egan, 1986). We had been encouraged by the level of awareness of the need for personal and professional support, demonstrated in one section of the questionnaire, and of the dangers of personal involvement in caring.

Until recently our programme with GP trainees has been somewhat superficial, consisting of a half- or whole-day session with a group of up to 30 individuals. The format has been primarily didactic, sometimes employing video or small group work with case histories. As a result of our survey of GP principals (MacLeod and Nash, 1991), we decided to offer the short course to those trainees who wished it and 22 accepted. We have also offered a similar course to GP principals and to date 54 have completed it.

The workshop is entitled 'Taking the lid off' indicating our willingness to address issues about caring for dying patients and bereaved relatives which affect us as people, as well as professionals. We wished to give permission to explore the painful areas of coping which we find difficult to share with colleagues and which we sometimes keep deep inside, for fear of seeming inadequate or unable to cope.

The first trainee group consisted of eight people. Our intention was to have ten, but two managed to misread the information. The GP course organizer also joined this group as a participant. The second group, planned for 12, was therefore 14, which we realize, with the benefit of hindsight, was too large. We normally co-facilitate such workshops so that we can draw on a multidisciplinary approach, using each other's diverse experience in palliative medicine and nursing, and so that one person is always available, if necessary, to work more closely with individual group members. Co-facilitation is helpful in providing a means of formative evaluation as the course progresses and a focus for the discussion of a change of direction if needed.

People bring all sorts of expectations and apprehensions to workshops and it is important to spend time discussing them. We use techniques which enable anonymity (for the apprehensions) and small group exploration (for the expectations). This provides the group with an opportunity to discuss and set an agenda, and also allows the facilitators an opportunity to allay fears. Fears about displaying emotion, appearing ignorant, or of specific activities (commonly role-play) are often uncovered, but are usually discussed to the group's satisfaction.

This activity leads to the establishment of ground rules for behaviour within the group. These include the level of confidentiality and support which members can expect if they choose to share painful or difficult experiences with the group. It allows participants to choose their level of involvement. It may also be useful to discuss the level of facilitator intervention expected by the group in situations which could be uncomfortable, perhaps when individuals 'take over' or withdraw from the group, or when the group process appears to be sabotaged by one group member for whatever reason. Such specific and overt agreement at this stage can be difficult to reach, but enables easier intervention if problems arise.

The initial sessions are often didactic and information-giving. Creating a framework for effective symptom control followed by some opportunities to try out this framework with difficult symptoms can reinforce knowledge already gained. We have occasionally presented a simulated patient who can be interviewed regarding symptoms, and this may help consolidate learning (Jolly, 1972). Feedback is important and time is taken to clarify points that are raised.

The following sessions are designed to look at the concepts of loss, grief and bereavement. We feel it is important that these should be addressed on a personal level and the first of the experiential exercises is used here. A short extract from the *Bambi* story, about the anticipated separation of leaves from a tree in autumn, is read aloud and followed by the writing of letters about the anticipated loss, which can be anonymously shared within the group. The use of symbolism in this way enables individuals to react with some distance if they prefer, addressing the issue within the context of leaf and tree, or to read a deeper, human and personal meaning into the story.

The issue of loss, and the related personal and professional feelings engendered by the exercise may be uncomfortable, and group members' reactions are varied. There is often some giggling, probably due to discomfort and embarrassment, and comments are raised about the significance of the exercise. However, the exercise may have a more profound effect and some individuals immediately identify painful losses in their own experience. Both of these examples can precipitate wide-ranging discussion and the objectives of the session can be addressed. Time must be given for evaluation of this exercise and we consider that this is more appropriately done within the group, either as a whole or in smaller units, and that the facilitators need not be present during that time. Our experience is that the development of a supportive group atmosphere is more likely to occur in our absence.

Exercises to facilitate an examination of loss on a broader scale can use what may appear to be insignificant losses. Imagining such events as the loss of car keys or credit cards, enables the participants to define the process of grieving, while acknowledging the often confused feelings which are also present. This sort of exercise provides an introduction to a discussion of the classical descriptions of the processes of grieving that are often confirmed by the individuals' personal and professional experiences (Bowlby, 1979; Kubler-Ross, 1970; Parkes, 1972; Worden, 1983).

In order that these stages of loss or grief can be adequately explored some listening skills and basic counselling principles need to be learnt. These are addressed in small group work again using everyday examples of listening skills from group members. Skills are identified within Heron's six categories (Heron, 1985) and placed within a problem-solving framework (Egan, 1986).

We decided, following a didactic information-giving session, to role play for the group so that they could be involved in decision-making using the information given, without the need to role play themselves. This technique (Jolly, 1972) demands that the facilitator interview a 'patient' or 'client' in a 'fish bowl' with group members able to influence the intervention.

In this way group members are able to be involved in an unfolding scenario, influencing its progress, and able to see the results of their decision making immediately. Feedback from the 'patient' about the decisions made, prior to de-rolling, can be helpful by detailing the positive and negative aspects of the interventions.

Such a technique may be used to demonstrate the effects of decision making in symptom control, or can be effective in exploring psychosocial or spiritual problems. Feedback suggests that group members find these sessions enjoyable and stimulating, do not feel in any way threatened, can become as involved as they wish and can observe the immediate effects of their decisions about intervention, enabling them to review their approach.

Feedback must be non-judgemental and based on evaluation of the effect of interventions on the patient and the exploration of possible alternatives.

We have developed case histories to examine some of the problems highlighted by individuals and groups. We address the problems of how to deal with patients who deny the presence or progress of the disease; how to deal with patients or relatives angry at diagnosis; collusion; and of those individuals who view life as hopeless or meaningless.

We feel it is important to look at how terminal illness affects family groups. We use the technique of 'sculpting', whereby a family situation is recreated by the 'sculptor', who places group members in the position of family members and involved professionals. It is dependent on physical expression and some groups may become particularly creative and symbolic in their interpretation of a situation. It enables a three-dimensional view to be taken which can be enhanced by interview of the participants or by attempts to change the dynamics of the situation, by trying things out which may bring about some improvement or change. Such exploration may enable the 'sculptor' to view a familiar situation from a different angle and to explore new scenarios.

However superficial such a technique may appear, the participants inevitably bring much of their personal selves with them to the role, and the facilitation must create safety and choice, and be ready to offer support to those who need it.

A final session will usually address the difficulties highlighted by an approach to care which allows personal involvement. The need for support and coping mechanisms are discussed, with some guidance in the development of a healthy balance, acknowledging stressors and becoming aware of our own needs.

Group development

Medical education at undergraduate level has only recently recognized the value of effective small group learning. Ruddock (1978) discusses some of the problems which arise in discussion groups due to the tutors' inability to relinquish their role as an authority or the unwillingness of students to allow them to do so.

We found that the trainees were unwilling to believe that they could be in

control, and when we stood back and allowed situations to develop they felt we were playing games and, indeed, manipulating them. This issue, thankfully, was voiced and we were able to explore it together, somewhat painfully.

At times the trainees felt the need to react to situations which were emotionally difficult with jokes and childish behaviour. Whilst accepting this reaction to some extent in the face of threat we found it difficult when it continued throughout the workshop. The smaller group dealt better with whatever the underlying emotions were and eventually left them behind, finding some security both with each other and with us. The larger group never felt such safety.

Perhaps group dynamics were already set before the workshops. It has been demonstrated that the most fluent speakers tend to be popular (with occasional exceptions) and are usually seen as more influential in getting a solution or view accepted (Kelvin, 1965). Indeed, a student writing about discussion groups (Seale, 1977) noted antagonism between noisy and silent members. Our facilitation work is of paramount importance in handling such problems and it may be that any potential difficulties are highlighted in such an atmosphere.

Evaluation of the course both for trainees and for principals has been undertaken since its inception. Pre- and post-testing are routine and opportunities to add to these evaluations are given both at the end of the three days and at follow-up days later. We are currently reviewing data from both the trainee and principal workshops, and the results will be published elsewhere.

Conclusions

The expectations of the group members at times challenged our educational philosophy and our beliefs about adult education. While it remains difficult to evaluate the success or otherwise of the teaching strategies employed, we remain convinced of the need to acknowledge the skills group members bring with them, and to explore these with an awareness of the personal investment doctors make when caring for dying and grieving people.

Our intention of creating a safe environment in which doctors can confront their fears and insecurities in this area – ‘taking the lid off’ – is supported by the personal growth that has been identified by some group members and the acknowledgement, almost without exception, by those attending of the need for such supportive exploration.

This paper has detailed the development of a workshop for GP principals and trainees who wish to explore physical and psychosocial skills involved in caring for dying patients and grieving relatives, within the context of their personal and professional investment in that area.

References

- MacLeod RD and Nash A (1991) Teaching palliative care in general practice (in press).
- Jolly B (1972) A review of issues in live patient simulation *Programmed Learning and Educational Psychology*, 49, 4, 200–204.
- Bowlby J (1979) *The making and breaking of affectional bonds*. Tavistock, London.
- Kubler-Ross E (1970) *On death and dying*. Tavistock, London.
- Parkes CM (1972) *Bereavement. Studies of grief in adult life*. Penguin, Harmondsworth.
- Worden JW (1983) *Grief counselling and grief therapy*. Tavistock, London.
- Heron J (1985) *Six category intervention analysis*. Human Potential Research Group, University of Surrey, Guildford.
- Egan G (1986) *The skilled helper*. Brooks Colt Publishing Company.
- Ruddock I (1978) *Learning through small group discussion: a study of similar work in higher education*. Society for Research into Higher Education, Guildford.
- Kelvin I (1965) *The study of groups*. Routledge & Kegan Paul, London.
- Seale C (1977) The discussion group. *Journal of Further and Higher Education*, 1, 1, 22–25.

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The Problematic Nature of Education in Palliative Care

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Abstract/ As the need for palliative care increases, palliative care is emerging as a field of medical care in its own right. At the same time there are many aspects of palliative care that are problematic, particularly in palliative care education. The aspects reviewed here include: (a) the lack of a long tradition and adequate conceptualization of palliative care; (b) the significance of psychological, emotional, and spiritual aspects; (c) the importance of but inadequate understanding of symptom control; (d) the fact that palliative care is not curative in the accepted sense; (e) its multiprofessional nature; (f) the range of different settings of palliative care; and (g) the fact that palliative caregivers have to perform their duties in situations where the emotional and psychological demands on them may be immense. A number of general issues relevant to palliative care education are also reviewed.

Résumé/ Au fur et à mesure que la demande s'intensifie, les soins palliatifs sont à créer leur propre place en tant que spécialité médicale. Cependant, plusieurs aspects de cette spécialité, dont la formation des intervenants, demeurent problématiques. Dans cet article, nous traitons des points suivants : a) l'absence de tradition et de normes dans la conceptualisation de programmes de soins palliatifs ; b) l'influence des aspects émotionnel et spirituel sur la maladie ; c) l'importance du contrôle de la douleur et la nécessité d'acquiescer des connaissances adéquates en ce domaine ; d) la nature palliative et non curative de la discipline ; e) l'interdisciplinarité ; f) la diversité des cadres où l'on dispense les soins palliatifs ; g) l'environnement difficile dans lequel les professionnels de la santé évoluent et les exigences émotionnelles et psychologiques liées à leur travail. Nombre de problèmes généraux en ce qui a trait à la formation y sont également abordés.

INTRODUCTION

Over the last quarter of a century, palliative care has emerged as an identifiable specialty that embraces many disciplines in the field of health care provision. It has been defined as "The active total care, by a multiprofessional team, of patients whose disease is not responsive to curative treatment. Control of pain, of other symptoms, and of psychological, social and spiritual problems is paramount. The goal of palliative care is achievement of the best quality of life for patients and their families" (1).

The need for palliative care will increase both nationally and internationally over the coming

years. The vast majority of those presently receiving palliative care have cancer, and national projections for the UK indicate that by the year 2000 the cumulative increase in the incidence of cancer could be between 13% and 20%. Cancer now claims more victims in developing countries, 2.7 million deaths per year, than in the developed world, with 2.4 million. There is, perhaps, an even greater need for palliative care among non-cancer patients. By the year 2000, roughly 67% of the world's 600 million elderly people will be living in the developing world, compared to about 50% in 1960 (2).

It is estimated that approximately 2.5 million caregivers over retirement age are caring for someone older and more sick than themselves. Already in Britain two thirds of all women over 75 live alone (3).

As the need for palliative care increases, so does the need for palliative care education. However, the nature of palliative care means that teaching and learning about it are complex and problematic. The purposes of this paper are to explore some of those issues and to make the case for a critical exploration of the teaching and learning of palliative care.

THE NATURE OF PALLIATIVE CARE

The Historical Context

The hospice movement has been an important focus in the development of palliative care. The modern hospice movement dates only from 1967 when Cicely Saunders opened St. Christopher's Hospice in Sydenham, London. There had previously been a handful of long-established Catholic hospices in Britain and Eire, but St. Christopher's has become the symbolic reference point for the start of the "movement".

In February 1987, the Department of Health and Social Security in England and Wales asked all health authorities to review their services for patients who were terminally ill (4). In November 1987, the Royal College of Physicians recognized "terminal care" as a new subspecialty of general internal medicine and called it palliative medicine (5). In the UK the Joint Committee on Higher Medical Training approved a training program for

senior registrars in palliative medicine (6). These developments were coincidental with a public becoming increasingly anxious about apparently intractable pain, a fear of dying, and the growing prominence of cancer as a cause of death (for example, see Cameron (7)).

The hospice movement has demonstrated that cancer symptoms, especially pain, can largely be controlled without distressing side effects. It has also shown that communication and discussion about terminal illness with patients, families, and caregivers are possible to the benefit of all parties.

By January 1993, there were 193 inpatient units throughout the United Kingdom in addition to 216 hospitals with support teams or support nurses and over 200 daycare hospices for palliative care, either free-standing or attached to hospice inpatient units or teams (8).

Palliation As an Emerging Field of Care

For some the field of palliative medicine may be relatively easily defined, e.g. in the curriculum published jointly in the UK by the Association for Palliative Medicine and the Royal College of General Practitioners (9). On the other hand, Scott and Macdonald state, "In the context of training and education the definition and description of palliative medicine has yet to receive clear demarcation" (10). This is also the case with palliative care.

It is generally accepted that the discipline of palliative medicine can be recognized as having the following relatively clear objectives:

- to relieve the physical and non-physical symptoms of advanced disease, maintaining an optimum quality of life;
- to influence caring in the chosen environment — home, hospital, or hospice — permitting independence for as long as possible;
- to support patients, families, other caregivers, and staff before and during bereavement;
- to facilitate and coordinate communication and collaboration between various agencies;
- to seek to influence patterns of care through education;
- to advance knowledge and practice by encouraging participation in research.

It could be argued that these are also the objectives of palliative care, although the objectives of palliative care are probably broader and more difficult to specify.

The relatively short life of palliative care to date means that there is not a long history of academic exploration and scrutiny. The essence of hospice care is the provision of "good quality care", addressing the emotional, physical, social, and spiritual needs of patients and caregivers. This "good

quality care" is often ill-defined and difficult to measure. Clinical audit is an increasingly important tool in medical practice, and no less so in the field of palliative care, but this paradoxically may pose a threat to some principles of palliative care. There is a danger that the physical dimensions may inevitably take priority over the other aspects that make up the totality of care, because they lend themselves more readily to scrutiny and measurement. Because of this difficulty in measurement, there is for some a difficulty in conceptualization. Academic medicine is so often assessed in quantitative terms that qualitative evaluation is sometimes difficult to grasp.

The relationship between palliative care and palliative medicine is also an issue. Much of modern medicine is concerned with care. The Greco-Roman origins of Western medicine suggest a medical model for illness. Diseases are problems that have solutions. Kearney has argued, as have others, that in developing its competence, Western medicine has lost its caring (11). The emergence of palliative care is seen as a compassionate response to needs not being met by developed Western medicine. As an emergent field, however, it is restricted by the poorly developed conceptualization that often accompanies new areas of care. Our understanding of spiritual issues, for instance, is sadly often limited to religious beliefs or opinions without adequate reference to or exploration of the true significance and meaning of our spirituality. It can be argued that this field of meaning, when accompanied by an understanding of the nature of being, is far more important to a patient than the physical elements which are much more readily addressed.

A further implication of the emergent nature of palliative care is that the elements that make up a "good" palliative care physician have not yet been defined. Is it the practical skills, the diagnostic ability, or the investigative prowess suggested by Johnson (12)? Are there particular personal attributes that are essential or desirable for a doctor entering this field (13,14)? Is there a requirement for a certain attitudinal development and/or empathetic understanding? Or is there even a correct moral viewpoint?

The fact that palliative care is an emergent field has many implications for palliative care education. The educator is faced with the challenge of educating caregivers about a domain of practice of which the limits, objectives, and nature are neither clearly defined nor unequivocally agreed upon by the different practitioners involved.

The Problematic Nature of Symptom Control

Most patients dying of cancer experience symptoms of one sort or another. Two thirds of these will experience pain. Twycross and Lack (15) rec-

ognized a lack of time for adequate teaching for symptom control in the undergraduate curriculum. They reported that they were constantly stimulated by distressed patients and forced to work from first principles in a "seemingly never-ending series of unique clinical situations" (p. ix).

Mason and Fenton (16), in a significant study of undergraduate education, outlined a longitudinal study about terminal care teaching at different stages in the undergraduate curriculum. The study identified a need for specific teaching on pain relief.

The development of expertise in the field of pain control has given a certain credibility to the discipline of palliative care, although it is still inadequately understood by many. It is worth noting that there are equally distressing symptoms, for example breathlessness, that may be just as common as pain but have not attracted the same degree of interest or investigation. There may be a further difficulty here in contextualization. These symptoms often appear in dimensions new to most people's previous experience. Severity and persistence are often the hallmarks of difficult symptoms at the end of life. These can cause considerable distress to the practitioner and have the potential to distort the framework within which he/she makes professional judgements.

For the palliative care educator there are many challenges here. Teaching must acknowledge the true complexity of symptom control of the terminally ill, recognize the importance of reflecting on and learning from experience, and allow opportunities for collaboration between practitioners.

Palliative Care Is Not Curative

If the medical model of illness is used to conceptualize palliative care, this care cannot be viewed as curative in the accepted sense. Although it can be argued that all care is essentially palliative, in many medical interventions an outcome considered to be only palliative is neither desirable nor satisfactory. To "make well" in the conventionally accepted sense is likely to be an important motivation of those entering the medical and nursing professions. Palliative care may not satisfy that motivation.

This issue is likely to be further complicated. For example, Feifer (17) has suggested that medical students enter medicine precisely because of their desire to overcome an above-average fear of death. Much has been written about the training of medical students and the "certainty" that is engendered in that training (see for example, Atkinson (18) and Fox (19)). On the wards and in much of their subsequent practice, medical students encounter patients who have "some well-established, observable and relatively discrete pathology" (18). In palliative medicine the pathology is undoubt-

edly present, but so many other different facets appear or develop that uncertainty is enhanced. Current teaching in palliative medicine may well compound this problem. Mason and Fenton (16) have pointed out that palliative care is an area that provides little satisfaction for medical students and indeed engenders considerable anxiety.

The non-curative nature of palliative care may not be an issue for all those involved, some of whom have made a deliberate choice to care for terminally ill patients. However, it remains an important issue to be addressed in palliative care education, together with such other aspects as the uncertainty of palliative care and the anxiety developed in the caregiver during his/her work.

Individual Expertise and Teamwork in Palliative Care

Responding to the particular needs of individual patients is fundamental to all medical care. The palliative care needs of the terminally ill are likely to be more wide-ranging than the needs of the non-terminally ill. In the delivery of palliative care, those needs will be met by individuals and teams of different kinds. The range of individuals in those teams allows palliative care to be multidisciplinary and multiprofessional in a way that other specialties in medical care are not. The relatively restricted nature of many other forms of medical care encourages a greater clarity of role definition for caregivers. Arguably, in these cases roles are more likely to match professional titles, and doctors and nurses in those situations are more likely to be clear about the boundaries of their professional roles. Within hospice care teams, occasional difficulties arise in the grey area between medical and nursing functions, as roles become blurred. The potential for role confusion or overlap is exacerbated in palliative care because the palliative care team may include a chaplain, social worker, physiotherapist, and occupational therapist in addition to conventionally defined doctors and nurses. The nature of palliative care and the variety of patient needs may challenge established hierarchies, and the wide-ranging and varying needs of individuals mean that team roles will vary also.

The practice of collaboration in teams has further implications. There is the difficulty of sharing knowledge in the care setting. The complexity of palliative care knowledge and its use as a basis for action present a particular challenge for those faced with the task of explaining aspects of palliation to others. This task may be yet more challenging because others in the team may not adhere to the same "framework for understanding" which is essential if a sharing of understanding is to take place. This may be because that framework is not

yet developed, as in the case of a student, or is of a different kind, as occurs in multiprofessional teams. Meyer, in a study of lay participation in care, has outlined many of the problems connected with it, highlighting the fact that despite an apparently multidisciplinary team approach, various factors inhibit a collaborative approach to care (20). Most professional groups within such teams employ a task-orientated or problem-solving approach to care, whereas a more patient-centred approach (as espoused by most palliative care organizations) demands the development of flexibility and supportive skills to foster individual patient care. This flexibility and skill should be developed in an interdisciplinary team in order for them to be used most effectively.

The implications here for palliative care education are significant. The task is not solely one of teaching palliative care but also of encouraging those involved to understand fully, and to be able to articulate to others, their theories and bases for action and to develop in other caregivers a framework for the understanding of practice. There is also the important task of developing collaborative practice so that caregivers are able to work effectively in teams and understand the nature of their role in them.

The Emotional and Psychological Demands of Palliative Care

Hafferty (21) has identified specific problems in medical training relating to "feelings" inculcated during that training. He identified a variability with respect to affect that can be traced to the tension between medicine's dominant values of detachment and distance and the lay values of concern and affectivity. His study characterized individuals wrestling with these concepts; they were unable to resolve the emotional difficulty of practicing clinical medicine without enjoying any formal institutional support for their continued efforts to maintain a sense of self as sensitive, caring, and reflexive social beings. Over time, he suggested, it was easy to tire of the struggle. The emotional and psychological demands of palliative care are immense. The distance and detachment that are possible and perhaps even desirable in other forms of medicine are not so in palliative care. Indeed, there is a case for arguing the opposite, i.e. that engaging with the patient is a central and essential feature of palliative care. Further, to tire of the struggle to be caring and sensitive — as a consequence of the overwhelming demands — would be a negation of the principal theme of palliative care practice. Clearly there is a need to acknowledge these issues in the practice of palliative care, but they must also play a part in palliative care education, so that future practitioners can

understand and cope with the demands that will be made on them.

The Wide Range of Settings for Palliative Care

As palliative care emerges as an important field in medical care, and as a conceptualization of it emerges also, it is becoming clear that it needs to take place in a wide range of settings, e.g. hospital, hospice, nursing home, patient's home. This has implications for the contextualization of the professional knowledge held and used by palliative caregivers. Context is not concerned solely with location, but also with its physical features, important but unwritten rules and routines, significant aspects of its culture, and so on. Interacting with this are the contextual aspects of the patients' medical and care needs. These include where patients live, the quality of support available to them in their homes, and a range of other factors. The basis for choosing the most appropriate location for palliative care is therefore an important element of palliative care knowledge; addressing this is an important aspect of palliative care education.

The Antecedents of Professional Knowledge

As in other professional activities, such as teaching (see, for example, Calderhead (22) and Connelly and Clandinin (23)), the palliative care practitioner's prior experience is likely to have a significant impact on his/her practice and professional development. Prior experience is likely to shape both the way professionals learn and their learning needs, their perspective of palliative care, what they consider to be important priorities, how they relate to others involved in the care process, and their ability to articulate and explain the bases of their actions. Importantly, prior experience is also a significant influence on their motivation to care for the terminally ill. This may appear obvious, but there are important educational implications. Prior experience represents an important starting point and should be continually revisited as part of the professional development process.

DISCUSSION

The previous section has sought to highlight some of the complexities of palliative care and its problematic nature, together with the consequences these have for palliative care education. A number of issues have been raised, many of which are the result of the relatively recent emergence of palliative care as a field in its own right and the complicated nature of professional knowledge and its acquisition by practitioners.

The approach taken in this paper, that of identifying, separating out, and analyzing different aspects of palliative care, was adopted deliberately

in order to further understand the requirements of palliative care education. Such a strategy, however, is not without its drawbacks. One drawback is that it can lead to a "technologizing" of palliative care education, an approach which denies its complexity and views it as a set of discrete instrumental responses to the different aspects of palliative care. This vision of palliative care is not an appropriate one, because it fails to do justice to its holistic character with its multiplicity of interrelated, interconnected, and dynamic facets of a personal, technical, practical, moral, social, emotional, and spiritual kind.

A second drawback is that it can lead to a bureaucratic response to learning about palliative care, one in which teaching is founded on a deficit model. Such a simplistic response would be characterized, for example, by the reliance on didactic approaches which seek to transmit knowledge about palliative care to those "who do not know", or by an overemphasis on behavioral objectives for learning activities which promotes a depersonalized and technical view of palliative care. It is not likely that such simplistic approaches can meet the needs of the palliative care learner.

Despite this, in a survey of medical palliative care teaching practice in the UK, MacLeod reported that didactic approaches dominate with 66% of the content topics being taught by means of lectures (24). This may in part be explained by the lack of training of medical palliative care teachers, since he also reported that only one sixth of the respondents in his survey had received any training in teaching methods and strategies. The criticism of lectures and didactic approaches in palliative care education is not to say that no aspects of palliative care can be taught as factual knowledge. It does, however, assert that palliative care is best characterized by forms of knowledge which are personal and shared, which seek to reveal meaning through interpretation, and which have moral and spiritual dimensions. Likewise, the criticism of an approach based on behavioral objectives is not an assertion that educational activities should not have intentions or purposes. It is simply recognizing that the complexity of many aspects of palliative care make it impossible to predict and specify the nature of the educational outcomes in any prescriptive way. Methods of education in palliative care education must match the true character of palliative care knowledge and, possibly more importantly, must recognize and draw upon the ways in which practitioners have actually acquired their expertise. An important implication arising from this is that more research is required into the processes of palliative care education, research which focuses on such questions as: "How do people learn palliative care and how can this learning be improved?"

One of the more important issues to arise from this analysis comes from the collaborative nature of palliative care and the relationship between individual expertise and teamwork. Much emphasis in palliative care is placed on the inclusion of the patient and caregivers in decision making and planning, so that when objectives for care are set, the patients' needs are met appropriately, efficiently, and effectively. An implication of this is that a similar approach should be adopted in all phases of palliative care education, so that learners can participate jointly at every stage from planning to evaluation. In this way the educational medium becomes the educational message.

In the context of the collaborative nature of palliative care, the terms "multidisciplinary" and "interdisciplinary" should be clarified. The term *multidisciplinary* suggests activities that involve the efforts of individuals from a number of disciplines — these efforts are discipline-oriented. On the other hand, the term *interdisciplinary* refers to activities programmed towards a common goal by individuals from a group of disciplines. However, in this case individuals not only require the skills of their own discipline but also have the added responsibilities of the group effort on behalf of the patient. This implies the need to perform effectively in a group (25).

The most appropriate way to promote attitudes which facilitate the use of interdisciplinary teams is to use an interdisciplinary approach in the educational setting. Using such an approach, each team member comes to understand the practice of the other disciplines and their roles in palliative care. The intention should not be the development of the technical skills needed by all the different disciplines but should be the enhancement of interdisciplinary functioning, including the molding of behavior to be adopted by all palliative care professionals (26).

Although there have been programs for education involving more than one discipline, there is little evidence from evaluations that they have been effective in achieving joint interdisciplinary objectives (27). In fact, there are few published evaluations of palliative care education programs at all. Evaluation does not appear to be a feature of palliative care education generally. Less than half the physicians questioned by MacLeod evaluated their teaching by using written evaluation forms (24). There are, however, some promising developments and some using innovative media. For example, the interactive computer program "Unite the Team!" calls on the primary health care team to work together to solve palliative care problems using the strengths of that team (28).

Although Meyer (20) highlighted the problem of the lack of team leadership in a multidisciplinary

team — an issue that could be readily addressed in an educational setting — a further issue is that of physician dominance inhibiting interdisciplinary team collaboration. However, in the multiprofessional workshops described by MacLeod and Nash (26), the acknowledgement and attention to the hierarchy within those teams became an element to build on rather than one that inhibited team learning. Meyer suggested that policymakers establish ways in which professionals can learn to work more closely together, but perhaps it is equally important that they work to learn together in order to shift from a uniprofessional to a multiprofessional approach. By learning together and reflecting in, on, and about problems (see James and Clarke (29), and by sharing such reflection in collaborative practitioner models akin to those described by James and Clarke (30), caregivers become more sensitive to the needs of patients and caregivers and perhaps understand better how to help them. This sharing of knowledge encourages the building of a framework within the caring team that enhances the quality of practice.

SUMMARY

This paper has explored some of the issues that are problematic in the teaching and learning of palliative care. It has outlined some of the development of the field and has explored elements of the specialty that present particular problems to educators. Aspects of teamwork and interdisciplinary care have been illuminated, and particular reference has been made to some of the problems of current practice reported in the literature. It is hoped that by approaching the subject in this manner, teachers and learners in palliative care will be stimulated to further discuss and explore these problems, improving both the quality of education and the quality of care in this important emerging field.

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REFERENCES

1. World Health Organization. Cancer Pain Relief and Palliative Care: Technical Report Series 804. Geneva: World Health Organization, 1990.
2. Stjernsward J, Koroltchouk V, Teoh N. National policies for cancer pain relief and palliative care. *Palliat Med* 1992; 6: 273-276.
3. Ford G. Palliative care: a wider horizon. *Palliat Med* 1992; 6: 91-93.
4. Department of Health and Social Services. Health Services Development: Terminal Care. Heywood, Lancashire: Health Publications Unit (HL/87/4 and LAC/87/2), 1987.
5. Hillier R. Palliative medicine: a new specialty. *Br Med J* 1988; 297: 873-874.
6. Ford G. Specialist medical training in the UK. *Palliative Medicine* 1988; 2: 147-152.
7. Cameron NM. Death Without Dignity. Edinburgh: Rutherford House Books, 1990; pp. 66,153,170.
8. Directory of Hospice Services. Sydenham, Kent: St. Christopher's Hospice Information Service, 1993.
9. Association for Palliative Medicine and the Royal College of General Practitioners. *Palliative Medicine Curriculum*. Southampton: Association for Palliative Medicine, 1993.
10. Scott JF, MacDonald N. Education in palliative medicine. In: Doyle D, Hanks G, MacDonald N (eds). *The Oxford Textbook of Palliative Medicine*. Oxford: Oxford University Press, 1993.
11. Kearney M. Palliative medicine — just another specialty. *Palliat Med* 1992; 6: 39-46.
12. Johnson I, Rogers C, Biswas B, Ahmedzai S. What do hospices do? A survey of hospices in the United Kingdom and the Republic of Ireland. *Br Med J* 1990; 300: 791-793.
13. Jenkins L. Personal communication, 1993.
14. Daley AG, Lennard RF. Training for palliative medicine. II. How should palliative physicians be trained? An observational study of the clinical skills needed by senior palliative physicians. *Palliat Med* 1991; 5: 303-306.
15. Twycross R, Lack SA. *Symptom Control in Far-Advanced Cancer: Pain Relief*. London: Pitman, 1983.
16. Mason C, Fenton G. How successful is teaching on terminal care? *Medical Education* 1992; 18: 394-400.
17. Feifer H. Death and dying: attitudes of patient and doctor. Group for the Advancement of Psychiatry 1965; 5(2): 632-641.
18. Atkinson P. Training for certainty. *Soc Sci Med* 1984; 19(9): 949-956.
19. Fox R. Training for uncertainty. In: Merton RK (ed). *The Student Physician*. Cambridge: Harvard University Press, 1957.
20. Meyer J. Lay participation in care: a challenge for multidisciplinary teamwork. *J Interprofessional Care* 1993; 7(1): 57-66.
21. Hafferty FW. *Into the Valley: Death and the Socialization of Medical Students*. New Haven: Yale University Press, 1991.
22. Calderhead J. *Teachers' Professional Learning*. London: Falmer, 1988.
23. Connelly MF, Clandinin DJ. *Teachers as Curriculum Planners: Narratives of Experience*. New York: Teachers College Press, 1988.
24. MacLeod RD. *Teaching Postgraduate Palliative Medicine*. Master of Medical Education Thesis 1992. Scotland: University of Dundee, 1992.
25. Melvin JL. Interdisciplinary and multidisciplinary activities and the ACRM. *Arch Phys Med Rehabil* 1980; 61: 379-380.
26. MacLeod RD, Nash A. Multidisciplinary palliative care education. Submitted for publication, 1993.
27. Nash A, Hoy A. Terminal care in the community — an evaluation of residential workshops for general practitioner/district nurse teams. *Palliat Med* 1993; 7: 5-17.
28. University of Glasgow. *Unite the Team!* London: University of Glasgow, University of Dundee, 1993.
29. James CR, Clarke BA. The development of reflective practice in nursing: issues and implications for nurse education. *Nurse Education Today* 1993 (in press).
30. James CR, Clarke BA. Beyond reflection to collaborative practice. *Nurse Education Tomorrow*, 4th International Participative Conference, Derby, September 1993.



EDUCATION IN PALLIATIVE MEDICINE: A REVIEW

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Abstract—The development of the speciality of palliative medicine has produced variable activity in the field of medical education. This article reviews published papers (primarily from Europe but with reference to other countries) identifies the extent of activity, and notes the absence of evaluative work. Undergraduate and postgraduate activity is identified.

The hospice movement has been an important focus for the development of palliative medicine. However, the relatively short life of the speciality means that there is not a long history of academic exploration.

Dame Cicely Saunders opened the first modern hospice unit at St. Christopher's in Sydenham, Kent, in 1967. By February 1987, the Department of Health and Social Security had asked all health services to review their services for patients who are terminally ill.¹ In November 1987, the Royal College of Physicians recognized terminal care as a new subspecialty of general internal medicine and called it palliative medicine. The Joint Committee on Higher Medical Training in the UK has approved a training program for Senior Registrars in palliative medicine.² It has been suggested³ that an increase in the number of full-time hospice doctors will facilitate coordination of district palliative care services and improve undergraduate and postgraduate education, but there has been little published evidence of this.

Some papers from the UK illustrate the situation there. Doyle et al⁴ undertook a survey of the education in terminal care available to general practitioners (GPs) and hospital doctors in Scotland. This showed that clinical instruction in the physical and emotional aspects of the care of the dying had been generally in-

adequate. Although there was no statistical analysis, Doyle concluded there was evidence that the educational influence of a hospice could be significant. In 1980, a Working Group on terminal care⁵ for the Department of Health and Social Security in England and Wales recommended that "a terminal care component should be included in the medical training of students." It also proposed that "all general practitioners and community nurses should have an opportunity to attend a course on terminal care." Field⁶ undertook an initial general review of the formal teaching in United Kingdom medical schools about death and dying. At the time of the survey, only four schools had no teaching. The predominant teaching methods used were traditional. There was demand from students for relevant teaching about death and dying. The evaluative work that had been undertaken was sparse and indicated only slight attitudinal changes. In a later study,⁷ Doyle investigated the involvement of British hospice organisations in medical undergraduate education in palliative care. Over 40% of hospices were giving clinical instruction in their units. He also noted that of the 30 medical schools in the United Kingdom, all had a participating palliative care service nearby. From the same study, he recorded that 50% of units were giving clinical instruction to GP trainees in their vocational training schemes. In this enquiry, he asked only for figures relating to lectures or clinical instruction (although there was some reference to 1-3- or 4-5-day courses for GPs). No further information concerning these courses was available.

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Thorpe⁸ has also looked at the teaching of undergraduate medical students. His survey (taken in 1988) showed that at 29 of the responding 103 British hospices, teaching of medical students took place. Most teaching was undertaken by doctors. He noted that small group teaching was the most common method, but a significant number of lectures were given. Oliver⁹ pointed out that not all medical students attended teaching sessions on the care of the dying and suggested that even those who did felt that their teaching had been inadequate. His work suggested many gaps in their basic knowledge of cancer and the drug control of symptoms.

Information about the effect of these kinds of courses is rarely published. There have been a few significant exceptions. Field and Howell,¹⁰ in Leicester, reported that students' major fears about breaking bad news were related to an inability to deal with reactions from patients and loved ones. In a later study, the same authors¹¹ stated that students felt that despite the teaching they had received, there was little they could do to alleviate the suffering of dying.

Mason and Fenton,¹² in an attempt to investigate prospectively, found that in spite of useful theoretical knowledge, the students concerned rated terminal care as a subject low in satisfaction and high on worry. In an important contribution to the understanding of the process of such education, they reported that no difference in knowledge and (perhaps more significantly) attitude could be discerned between those who had and those who had not attended a course or symposium on terminal care.

Anderson¹³ and Irwin et al¹⁴ have demonstrated that communication skills can be taught effectively and can influence the skills employed by students; the latter authors reported the use of a multidisciplinary approach to teaching.

Palliative medicine education in the United States is still comparatively new. In a study comparable to that undertaken by Field,⁶ Mermann et al¹⁵ surveyed 111 US medical schools. In 1989, the time of the survey, there

were still 11% (12 schools) in which no formal teaching was undertaken. Lecture was the predominant teaching method, and patient participation was usually confined to a class presentation.

There are few published references to courses available for undergraduates or internal medical housestaff, but Von Roenn et al¹⁶ report on such a program in palliative care education; evaluation indicates a definite perception of educational benefit by residents and enthusiasm for continued involvement in palliative care.

Some of the Canadian experience is illustrated by Burge and Latimer,¹⁷ who describe the palliative care program at McMaster University. They emphasize that the process there is a dynamic one that is influenced by student evaluation, interdisciplinary professional evaluation, and the changing nature of palliative care as it is practiced. In a survey in general practice and undergraduate cancer education in France, Ravaud¹⁸ records that 51% of GPs questioned stated that they were not taught about palliative care in oncology. They also comment on the inadequacy of teaching in pain control in oncology and palliative treatments generally.

Further investigation of the literature reveals little evidence to support widespread education in terminal or palliative care. Buchanan et al¹⁹ outline the situation in Australia, but no formal survey is reported. A model curriculum for undergraduate teaching is suggested.

The Education Committee of the European Association for Palliative Care (EAPC) has recently published a survey on the current status of professional education in palliative care.²⁰ They report variable activity in Poland, Belgium, Germany, and Italy for undergraduate medical students, with Sweden, France, Switzerland, and Poland providing multidisciplinary programs for postgraduates. They acknowledge that in the United Kingdom there is possibly more organized formal teaching in palliative care for medical students and postgraduates than in most countries. There is also now significant activity in the United States, Canada, and Australia. When it is con-

sidered that the modern hospice movement has been active in the United Kingdom for 25 years, it is perhaps surprising that more impact on undergraduate training has not occurred. Schofield's observation²¹ is relevant here:

The ideal of the physician who is both sensitive and sensible will remain a distant goal until we direct the priorities of the medical profession and the structure of medical education, creating an environment for caregivers in which compassionate care is seen as both desirable and realistic.

Against this background a review of postgraduate education is important. There have recently been innovations in the field of postgraduate education in palliative care leading to degrees or diplomas. The first of these was developed by Maddocks at the Flinders University of South Australia.²² He and his colleagues have developed an MSc/graduate diploma course (Primary Health Care) in palliative care, focusing on pain management, psychosocial aspects, and ethical issues in palliative care.

Finlay, at the University of Wales, is coordinating a Diploma in Palliative Medicine. This has been developed as a distance learning program aimed at doctors with some experience in the field in either primary care or hospital medicine.²³ Those completing the diploma are hoped to act as a resource in a given health district. Evaluative work is yet to be completed.

MacLeod and Nash²⁴ have outlined the development of a course specifically designed for GP trainees and principals. This course was based on previous investigation²⁵ of GPs' perceived educational needs and preferences. Their work follows the development of the course and looks at teaching styles and strategies as well as evaluation. They are currently evaluating these courses both quantitatively and qualitatively.²⁶

Scott and MacDonald²⁷ have provided an overview of activity but emphasize that educational methodologies are still far from clear. They reinforce that there is an increasing number of books, videotapes, audiocassettes, journals, etc that are available. James and MacLeod²⁸ have warned of the problem-

atic nature of palliative care education with the potential "technologising" and "bureaucratization" of this field in the search for quality measurement and effectiveness. Much discussion among teachers and learners in palliative medicine is needed to explore the issues. Dialogue with teachers in other spheres of education should minimize these problems and consequently improve not only the quality of education but also the quality of care in this important emerging field.

Perhaps two of the most pertinent comments in recent years are the following:

In the last ten years an awareness of the principles of palliative care has been brought to almost every young doctor . . . in Britain and North America. . . . [T]he biggest challenge lies ahead of us—to evaluate our teaching, to find means of teaching those who qualified with us, to research . . . our teaching.⁷

The challenge of those working in any branch of palliative medicine is surely clear. Those working in the field have the responsibility not only for carrying out their practice but also for making it better known. We not only have to work continually on our own professional standards but also to spread the knowledge that already exists.²⁹

REFERENCES

1. Department of Health and Social Security: *Health services development: Terminal care*. Heywood, Lancashire: Health Publications Unit (HL/87/4 and LAC/87/4/2), 1987.
2. Ford G: Specialist medical training in the United Kingdom. *Palliative Med* 5:147-152, 1988.
3. Hillier R: Palliative medicine. *British Med J* 297:874-875, 1988.
4. Doyle D, Parry KM, Macfarlane RG: Education in terminal care. *Royal College Gen Prac* 32:335-338, 1982.
5. Wilkes E: *Terminal Care: A report of a DHSS working group*. London: HMSO, 1980.
6. Field D: Formal instruction in United Kingdom medical schools about death and dying. *Med Educ* 18:429-434, 1984.
7. Doyle D: Education in palliative medicine and pain therapy. In Twycross RG (ed): *The Edinburgh Symposium on Pain Control and Medical Education*. London: RSM, 1989.
8. Thorpe G: Teaching palliative care to United Kingdom medical students. *Palliative Med* 5:6-11, 1991.
9. Oliver D: Training in and knowledge of terminal care in medical students and junior doctors. *Palliative Med* 3:293-297, 1989.
10. Field D, Howell K: Medical students self reported

- worried about aspects of death and dying. *Death Studies* 10:147-154, 1985.
11. Field D, Howell K: Dealing with dying patients: Difficulties and strategies in final year medical students. *Death Studies* 12:9-20, 1988.
 12. Mason C, Fenton G: How successful is teaching on terminal care? *Med Educ* 20:342-348, 1986.
 13. Anderson J: Evaluation of a practical approach to teaching about communication with terminal cancer patients. *Med Educ* 16:202-207, 1982.
 14. Irwin WG, McClelland R, Love AHG: Communication skills training for medical students: An integrated approach. *Med Educ* 23:387-394, 1989.
 15. Mermann AC, Gunn DB, Dickinson GE: Learning to care for the dying: A survey of medical schools and a model course. *Academic Med* 66(1):35-38, 1991.
 16. Von Roenn JH, Neely KJ, Curry RH, Weitzman SA: A curriculum in palliative care for internal medicine housestaff: A pilot project. *J Cancer Educ* 3(4):259-263, 1988.
 17. Burge FI, Latimer EJ: Palliative care in medical education at McMaster University. *J Palliative Care* 5(1):16-20, 1989.
 18. Ravaud A: A survey in general practice about undergraduate cancer education: Results from Gironde (France). *J Cancer Educ* 6(3):153-157, 1991.
 19. Buchanan J, Millership R, Zalcborg J, et al: Medical education in palliative care. *Med J Australia* 152:27-29, 1990.
 20. Doyle D (ed): *Survey on the current status of professional education in palliative care*. Geneva: EAPC, 1992.
 21. Schofield GR: Terminal care and the continuing need for professional education. *J Palliative Care* 5(3):32-36, 1989.
 22. Maddocks I, Donnell J: A masters degree and graduate diploma in palliative care. *Palliative Med* 6:317-321, 1992.
 23. Finlay IG, Stott NCH, Marsh HM: Distance learning in palliative medicine. *Eur J Cancer Care* 2:38-40, 1993.
 24. MacLeod RD, Nash A: "Taking the lid off"—observations of the process of palliative care education for general practitioners. *Postgrad Educ Gen Prac* 3:28-33, 1992.
 25. MacLeod RD, Nash A: Teaching palliative care in general practice—a survey of educational needs and preferences. *J Palliative Care* 7(4):9-12, 1991.
 26. MacLeod RD, Nash A, Charny M: Evaluating palliative care education. Submitted for publication, 1993.
 27. Scott JF, Macdonald N: Education in palliative medicine. In Doyle D, Hanks G, Macdonald N (eds): *The Oxford textbook of palliative medicine*. Oxford: Oxford University Press, 1993.
 28. James CR, MacLeod RD: The problematic nature of education in palliative care. *J Palliative Care* 9:4, 1993 (in press).
 29. Saunders C: Voluntary euthanasia. *Palliative Med* 6:1-5, 1992.

Multidisciplinary education in palliative care

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Summary *This paper looks at the development of multidisciplinary workshops for those professionals working with terminally ill people and their families. The workshops are described and early results of qualitative evaluations are reported with some observations about the impact on future practice.*

Key words: *Palliative care; multidisciplinary; education; evaluation; qualitative.*

Introduction

The Dorothy House Foundation was set up in 1976 as a community based hospice organisation for the Bath Health District (population 405,000) in the South West of England. Since its inception it has always included education as a prime objective and has, over the last five years, had financial support from Cancer Relief Macmillan Fund (a major United Kingdom charity) to develop that programme.

The Macmillan Education Centre of the Dorothy House Foundation states one of its major objectives as "providing uni- and multidisciplinary education for professionals in palliative care". Much of the current programme is unidisciplinary, meeting the educational needs of specific groups. One of the advantages of unidisciplinary learning is the assumption of a body of knowledge which can be made, and the subsequent building on that during the course. This leads to efficient use of time with such groups.

Many of these unidisciplinary groups have suggested that there would be benefit, in the field of palliative care, in exploring a multidisciplinary approach to learning as it is accepted by most in this field that palliative care is essentially a multidisciplinary activity. There is evidence (Carpenter, 1990) to support impressions that interprofessional education will be effective in overcoming barriers to collaboration if it:

- explores similarities and differences in roles, skills, knowledge and ideology;
- recognises the *complementary* skills and resources of different provisions;
- brings together course members of equal status in equal numbers;
- allows communication in whole groups which are not too large;
- has full institutional support to ensure participants' involvement.

A focus on multidisciplinary learning for its own sake may not be either efficient or effective.

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Indeed, a survey from ten countries concluded that proof of the benefits of good collaboration was meagre (Westin, 1986).

The survey, carried out in 1987–88, by the Institute of Community Studies for the Centre for the Advancement of Interprofessional Education (CAIPE) identified the interprofessional educational activity of 466 agencies. The survey helped also to identify specific course objectives for this type of activity, namely:

- to increase understanding of the roles/views of other professions;
- to promote teamwork/co-operation between professions;
- to increase knowledge of the course topic;
- to develop practical skills.

Storrie (1992) has researched the activity of a number of interprofessional Masters programmes in the UK and has observed that although most of these programmes were not established to focus primarily on interprofessional matters they were multidisciplinary in approach and content. They were also concerned to increase mutual professional knowledge and understanding.

The objectives outlined above, whilst they were not specific for the courses at the Dorothy House Foundation, are closely allied to the philosophy of the education centre and were foremost in our minds when planning the multidisciplinary programme.

Background to the development of the workshops

The service offered by the Dorothy House Foundation Hospice is particularly community orientated. The daily census of patients is in excess of 250 with a professional team of ten Macmillan nurses, one physician (a second physician was added in 1993), physiotherapist (part-time) and lymphoedema specialist (part-time). Only six in-patient beds are available in the assessment unit of Dorothy House for symptom control, rehabilitation, respite and terminal care. Forty day care places are available each week. The Bath Health District is fortunate in having a large number of community hospitals where patients can be cared for in their own community.

The education programme has developed to address issues particularly relevant to community care. Courses are predominantly for specialist nurses in the community (Macmillan nurses) and members of the primary health care team (family doctors and community nurses, health visitors, practice managers, receptionists in health centres), (MacLeod, 1993; MacLeod & Nash, 1992).

While content and level have been appropriate to each group, it became evident that themes remained the same and teaching and facilitating styles were similar. Evaluation regularly raised the issue of the difficulty, for members of a single discipline, of putting theory into practice on return to the team and often suggestions were made by course attendees that a team approach to learning might be a productive sequel to these unidisciplinary workshops. They felt that by a sharing of knowledge, skills and perhaps, most importantly, attitudes, they might provide more effective care in their different communities. Our experience of working with the multidisciplinary team employed by the Foundation and developing regular education programmes for those professionals gave us an opportunity to develop that theme for a broader group.

With this growing awareness invitations were sent to teams within the health district who were caring for dying people and their families to participate in a workshop aimed at promoting a multiprofessional approach to that care. Those targeted included primary health care teams (to include doctors, nurses, health visitors, midwives, receptionists, secretaries and pharmacists if appropriate) and specialist teams in the hospitals (the cancer unit and specialist

Table 1. *Workshop example: primary health care team*

1.	Agenda setting	—	small group work with feedback to large group
2.	Information giving	—	e.g. the role of the hospice team, assessment of difficult symptoms
3.	(a) Experiential learning	—	e.g. experiences of loss
	(b) Information giving	—	theories of grief and loss
4.	(a) Communication	—	reinforcement of basic listening skills through group work or paired exercises
	(b) 'Sculpting'	—	the scenario of a family with a dying teenager and the impact on family, friends and professional carers is observed and often experienced.
5.	(a) Action plan	—	'How will <i>we</i> do it differently?'
	(b) Formal evaluation	—	qualitative observation of participants

rheumatology teams to include doctors, nurses, radiologists, physiotherapists, occupational therapists and receptionists).

Description of workshops

The workshops varied in size from 15 to 31 participants. Each workshop was devoted to one team only (either primary health care team or specialist unit from hospital). Those attending workshops and courses bring with them much knowledge and experience, which must be acknowledged and utilised within the group. Within broad guidelines, we encourage group members to create a specific agenda for the workshop, addressing those issues which are of particular interest, and spending less time on areas with which the members feel comfortable. Decisions regarding content are followed, usually in small groupwork, by decisions regarding process, the group identifying methods of learning which are comfortable and acceptable and sharing their fears or discomfort with others. Typically groups identify the more experiential methods (such as role play) as more uncomfortable, and the ground rules which form the basis of the course must reflect this. Time spent on this part of the workshop gives essential value to the group and its knowledge and experience, and encourages 'ownership' of the work. Commonly there are a number of different areas of interest that these groups identify. Control of difficult symptoms (including assessment of those symptoms); concepts of loss and grief; communication skills (more particularly counselling techniques); coping mechanisms and stress management and planning for future care are those areas most commonly identified (Table 1).

Within the whole group there are advantages in both uni- and multidisciplinary small group work and decisions regarding facilitator style are important (Heron, 1989) in enabling autonomy in decision-making. Such 'autonomy' may be influenced by the pre-existing hierarchy in the groups described and this may require a different approach than that of a multidisciplinary group whose members do not normally work together. It is important to remember that relationships and hierarchy may be set and will continue after the conclusion of the workshop. This may be considered an inhibitory factor but could facilitate other elements of the work. The group dynamic should be observed with this in mind and may demand specific ground rules for its preservation and protection.

Doctors, particularly, are often unused to multiprofessional learning. They can tend to gravitate to one group or may even dominate another. Members of the team who do not have a direct clinical role (such as receptionists or secretaries) need to be encouraged to contribute and having done so often recognise their role in the 'caring' team more readily.

Initially there are opportunities for a more didactic (and perhaps 'safer') session where information about the Foundation or specific symptoms can be given. Succeeding sessions often deal with grief, loss and bereavement. We feel it important that an opportunity for a more experiential type of learning is not missed, believing that addressing these issues on a personal level is important. By looking at what may appear insignificant losses (for example car keys or papers) individuals can identify elements of grieving while acknowledging the often confused feelings that are also present. We use this sort of exercise as a way into a more formal discussion of the classical descriptions of the processes of loss and grief that are confirmed by individuals' personal and professional experiences. This sort of exercise can highlight the importance of 'active' listening skills. Small group work or paired exercises can often address this area adequately by drawing on the professionals' own experience of listening skills and, if necessary, by reference to standard works on this subject.

Further explanation of the importance and significance of communication follows. Using the technique of sculpting (Satir, 1978) we look at how terminal illness affects family groups and the individuals in the caring team. Sculpting allows individuals to experience the dynamics of a relationship or a situation and also allows others to observe a changing situation from 'outside'. Although it may appear a superficial technique it must be acknowledged that participants bring themselves into each situation and support is offered to those who may need it.

The situations that we use are either identified by the team (a difficult situation that they have recently come across) or by the facilitators. We would choose either a family with a dying teenager (to emphasise the importance of grief in friends and family as well as involvement of the hospital and primary health care team) or a grieving widow (to highlight problems of families grieving at different 'rates' and the involvement of a wide professional team). Towards the end of the workshop attention is directed to creating an action plan for the future ('How will we do it differently?' 'What will change in our practice?'). This is essentially an evaluative process that leads on to a more formal period of evaluation.

Evaluation

Consideration was given to the possibility of obtaining 'hard' data, by pre- and post-testing, as in previous evaluative work (MacLeod, Nash & Charny, 1994). At this stage, however, 'illuminative' evaluation (Parlett & Hamilton, 1972) is considered more pertinent.

It is interesting and important to hear from individuals regarding the course content and process and to encourage them to determine the success or otherwise of the achievement of their objectives. However, the main focus of the workshop is that of team and group process and this may be observed at the time and in retrospect. With this in mind we ask individuals to answer only three questions:

- One thing that I have learned?
- One thing that happened to me personally?
- One thing that happened to the team?

A later opportunity for evaluation by the team is in their reflections on the 'action plan' that was identified during the last session of the workshop.

Using techniques described by Miles & Huberman (1984) for cross-site analysis, we attempted to look at those qualitative elements of the evaluative process. The aim of this technique was to ensure that events and processes in one setting were not wholly idiosyncratic. Looking at processes and outcomes across many workshops should help, as those authors suggest understanding of how such processes are "bent by specific local contextual variations". In this way anecdotal evidence can be collated and interpreted more usefully.

Results of evaluation

Post workshop evaluation could be divided into comments concerning structure, process and outcome of the workshop. In a review of three primary health care team workshops, of 31, 26 and 15 participants (total 72), 55 evaluation forms were received (76%).

Structure

Some group members regarded the size of the group problematic and felt the lack of a written programme before the workshop difficult. Positive comments included the value of specifically allocated time for team learning and the need to be away from the workplace. Several group members commented regarding the importance of using external facilitators to enable the process. One member disliked the movement between small groups, while another found that changing groups "kept the interest going".

An awareness of the balance between the need for guidance or structure and the creation of a relaxed, 'free and easy' feel to sessions is important. Several group members, having remarked on the need for a programme or some idea of workshop structure, then commented positively about the unstructured nature of sessions.

Process

Many of the responses regarding process were about the experiential nature of the learning, in particular the use of sculpting and role play, which all who commented 'enjoyed'. Some indicated the importance of having choice about involvement in these activities, especially in having their choice respected when not wishing to be involved. There were many comments about feeling relaxed, 'free and easy', and about the amount of laughter, obviously not expected in such a workshop.

Outcome

The evaluation form attempts to elicit information regarding outcomes for participants, asking them to comment regarding any effect there may be for them as a result of the workshop as well as for the team. Such effects may have little or nothing to do with content but more to do with structure, i.e. being and sharing with colleagues, or with process, in being involved and valuing their own knowledge and ability. Many of the comments regarding outcome were specific in teamwork terms, anticipating improved communication and greater understanding of roles.

Those few who commented on overtly patient-related issues did so in terms of awareness, empathy and sensitivity to, particularly, psychosocial needs. It is possible to speculate that the safety and support needed to more effectively address these issues would be found in improved teamworking.

As far as the objectives identified by the CAIPE survey are concerned, these were invariably achieved. Much comment was made about the value of a better understanding of the roles of colleagues. The sculpting exercise invariably achieved a different degree of co-operation between team members than that which was initially demonstrated. Knowledge, in the area of palliative care, was increased by the didactic sessions and the provision of printed material. Practical skills, such as communication and listening, were reinforced.

Ideally, perhaps, evaluation should include description and analysis of the whole workshop including the attitudes of the participants and other people affected by the course, including

the effect of the participants on the facilitators and the potential for facilitator style affecting the participants.

Conclusion

It is our belief that workshops such as these can contribute to more effective management of patients and families where palliative care is indicated. Our own evolving style, through several similar workshops, has responded to our increasing awareness of the needs of such groups and a growing confidence in a less directive facilitative style. Where teamwork and team understanding is central to effective and sensitive care delivery, a directive and autocratic facilitator style is inappropriate.

Teams who have participated in the workshops may be able to help develop evaluative tools, based on their experiences following the workshop and, with the continued interest of primary health care teams in this area, we hope to develop this project further.

The development of clinical audit programmes that look at the effectiveness of team working and give an opportunity of sharing thoughts about different professional contributors is one way forward in this area of evaluation. An audit carried out before such a workshop and updated some time after it should indicate something of the effect of that learning activity.

This paper has described multidisciplinary workshops in palliative care for primary health care teams and specialist hospital teams. While we have no doubt in the value of such workshops, we are convinced that philosophy, rationale for development and choice of appropriate facilitator style are crucial to their effect and we will continue to develop our thinking and our approach accordingly.

References

- CARPENTER, J. (1990) Research in interprofessional education: criteria for evaluation. Report of *CAIPE 1st National Conference, London, UK*.
- HERON, J. (1989) *The Facilitators' Handbook* (London, Kogan Page).
- MACLEOD, R. D. (1993) Teaching palliative care to medical students and other care givers, *The Hospice Journal*, 9, pp. 55–67.
- MACLEOD, R. D. & NASH, A. (1992) Taking the lid off—Observations of the process of palliative care education for general practitioners, *Postgraduate Education for General Practitioners*, 3, pp. 28–33.
- MACLEOD, R. D., NASH, A. & CHARNY, M. (1994) Evaluating palliative care education, *European Journal of Cancer Care*, 3 (in press).
- MILES, M. B. & HUBERMANN, A. M. (1984) *Qualitative Data Analysis* (London, Sage Publications).
- PARLETT, M. & HAMILTON, D. (1972) *Evaluation as illumination; a new approach to the study of innovative programmes*. Occasional Paper No.9, Centre for research in the Educational Sciences, Edinburgh.
- SATIR, V. (1978) The Simulated Family in: SATIR, V. (Ed.) *Conjoint Family Therapy*, (London, Souvenir Press).
- STORRIE, J. (1992) Mastering interprofessionalism—an enquiry into the development of Masters programmes with an interprofessional focus, *Journal of Interprofessional Care*, 6, pp. 253–259.
- WESTIN, C. G. (1986) Primary Health Care: Co-operation between health and welfare personnel. *Eurosocietal Research Paper 8*, European Centre for Social Welfare Training and Research, Nergasst 17, 1090 Vienna, Austria.

Evaluating palliative care education

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Evaluating palliative care education

This paper illustrates the evaluation of some of the effects of a 3-day workshop for principals and trainees in general practice on a number of aspects of palliative care, using pre-, immediate and late post-tests. Further qualitative evaluation is attempted by including a questionnaire with the late post-test. The evaluation is to demonstrate significant shifts, or differences, in confidence in dealing with physical and psychosocial symptoms, and in participants' perceived ability to cope, and to support these findings with qualitative data where appropriate.

Keywords: education, palliative care, evaluation (medical, qualitative).

INTRODUCTION

Education is considered an integral part of the work of palliative care teams, yet there is little evidence to indicate the effect on practice of such education.

Surveys have been undertaken (Doyle *et al.*, 1982; Doyle, 1989; Thorpe, 1991), but these have not addressed in any depth the outcome of undergraduate education in palliative medicine. Field (1984) undertook an initial general review of the formal teaching in United Kingdom medical schools about death and dying. He found that the evaluative work that had been undertaken was sparse and indicated only slight attitudinal change. This view is supported by Mason & Fenton (1986) who, in an attempt to investigate prospectively, found that in spite of useful theoretical knowledge the students rated terminal care as a subject low in satisfaction and high on worry. They reported that no difference in knowledge or attitude could be discerned between those who had and those who had not attended a course/symposium on terminal care.

Anderson (1982) and Irwin (1989) have demonstrated that communication skills can be effectively taught and can influence the skills employed by students; the latter

author reported extensive use of a multidisciplinary approach to teaching.

In the field of postgraduate medical education there is little published evidence of palliative care education influencing practice. Coles (1989) reviewed the literature on the effectiveness of Continuing Medical Education (CME) and especially looked at what affects practice. He went on to devise a set of criteria by which to evaluate CME. He emphasized the importance of establishing an appropriate context for learning, reflecting 'where the learner is'; he asked whether the CME programme provided the necessary information and whether there were opportunities for people to handle the information. In other fields, there have been attempts at showing how experiential education programmes can influence practice in a positive way (Wergin *et al.*, 1989).

Evaluative work from degree or diploma programmes in palliative care has not yet been reported (Maddocks & Donnell, 1992).

There are many recognized problems of assessment and evaluation in medical education. Gale-Grant (1986) addressed many of the theoretical issues in curriculum evaluation and outlines a number of theories to be employed. Cronbach (1982) has stated that evaluation must be more than a summary of what occurred where a certain programme was in operation. He states:

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the proper function of evaluation is to speed up the learning process by communicating what might otherwise be overlooked or wrongly perceived ... Is the programme achieving its goals ...? Does the programme have an effect?

These questions assume that the form of the programme has been fixed in objectives and in process, and that the aim of the evaluation exercise is to assess its effect.

MacGuire (1990) has emphasized the importance of outcome evaluation:

Programme evaluation is both indispensable and inescapable. All programmes, both traditional and innovative, must ultimately be able to show that they have had a favourable impact on the health status of the population served by the learners.

Our research into the perceived educational needs of local general practitioners (MacLeod & Nash, 1991) suggested that a medical programme should address not only factual information, but also the psychosocial elements of care both on a personal and professional level. The survey findings confirmed our belief that such a programme should incorporate many of the principles of adult learning (see Schon, 1987; Brookfield, 1986).

A course was developed, based on the findings of this survey, aimed specifically at general practitioners, both principals and those in training. We were impressed by the need highlighted in the survey for exploration of personal support mechanisms. In acknowledgement of this perceived need, we felt the course title, 'Taking the Lid Off', and the course description should be explicit. Course content was divided between the factual information requested and time spent exploring the implications for doctors in becoming involved with psychosocial issues, both professionally and personally (MacLeod & Nash, 1992).

METHODS

Fifty-three principals in general practice and 27 trainees attended eight workshops, from February 1990 to January 1991.

A triangulated approach (Campbell & Stanley, 1966) to evaluating this course was employed. This sort of approach employs multiple methods or perspectives to collect and interpret data, in order to converge on an accurate representation of reality. Summative evaluation forms are routinely used for all courses at this centre. These address structure, process and outcome criteria.

Follow-up workshops were offered 6–12 months post-course, to further develop specific issues and to allow feedback. Self-rating (see Appendix A) was obtained using analogue scales with the left-hand anchor labelled as positive or negative in a random fashion.

The questions were concerned with the management of physical and psychosocial problems in palliative care; confidence and personal coping mechanisms, and their effect on caring for dying patients and families.

In support of this data, we included with the late post-test a further evaluative form (see Appendix B), which encouraged the identification of aspects of practice which had changed as a result of attendance at the course.

Participants received pre-test rating scales 1 month prior to the course. This was to provide both a starting point for post-course evaluation and to enable participants to identify for themselves some areas that they wished to address during the course. Self-rating scales were repeated immediately post-course and after 4–6 months.

A control group of 22 principals in general practice were also asked to complete a 'pre-test' rating scale to provide comparative data for later analysis.

Results from the self-rating scales were collated and comparisons were made between various groups. Comparisons were made between male and female, between trainees and principals, between attenders and a control group, and between pre-, post- and late post-test. We hoped to identify significant shifts in differences within these groups. Mean scores from the analogue scales (along with standard deviations) were calculated for each of the groups above and *P* values recorded with SPSS/PC+ (Norusis, 1988).

Responses to that qualitative evaluation are reported within personal and professional categories, and verbatim comments are included to support other findings.

RESULTS

Self-rating scales

Results are reported within the above categories, limited only to those which we felt were either interesting or statistically significant, specific to those categories. *P* values have been noted here, but reference to the tables for more detail is recommended.

Comparisons

No difference was demonstrated for either coping or confidence between attenders and a control group in the pre-test.

There was a significant precourse difference between trainees and principals in self-rated confidence ($P = <0.01$), but no statistically significant difference in previously experienced difficulty in coping between the two groups ($P = >0.1$). (Table 1b).

When asked about difficulty in coping personally with dying patients women had experienced difficulty more frequently than men ($P = <0.005$), but there was no statistical difference ($P = >0.05$) between men and women when asked about self-rated confidence (Table 1c).

Almost all attenders recorded an increase in confidence on late post-testing [Table 1d(ii)]; this was more marked for trainees than for principals ($P = <0.05$). Between pre- and post-tests [Table 1d(i)] there was an increase in confidence for most attenders ($P = <0.005$). Most participants felt their coping mechanisms were more effective after the course ($P = <0.05$) [Table 1d(iii)], this difference being significantly greater for trainees ($P = <0.05$) (Table 2). This

shift was maintained at the late post-test; more so for trainees than principals.

Qualitative questionnaire

All participants were contacted and 43 responses were received (81%). Of these, 28 responders were able to identify at least three separate areas that they felt had been influenced by attendance at the course. The responses fell naturally into personal and professional domains.

Personal

Personal issues included comments about coping, needs, feelings and increased security in dealing with difficult situations. These comments included:

Felt more secure personally, meaning it's alright to have difficulty facing dying patients.

Table 1. Comparisons

			No.	Mean	SD	P value
(a)	For attenders/control	Confidence (q3) physical	control	22	3.09	0.81
			attenders	67	3.26	0.94
		Confidence (q5) psychosocial	control	22	2.94	0.81
			attenders	67	3.33	0.78
(b)	For trainee/principal	Coping (q4)	trainee	23	3.11	0.89
			principal	44	2.92	0.86
		Confidence (q3 & q5) physical and psychosocial	trainee	23	7.28	1.46
			principal	44	6.23	1.39
(c)	By gender (inc. control)	Coping (q4)	female	43	3.25	0.84
			male	46	2.71	0.82
		Confidence (q3 & q5) physical and psychosocial	female	43	6.71	1.46
			male	46	6.22	1.49
(d)	Pre/post/late test	Confidence (q3 & q5) incl. conf.	pre	66	6.59	1.50
			(imm.post	66	5.73	1.43
			(late post	66	5.68	1.44
			(trainee	23	-2.18	2.11
		Pre-post differences	(principal	43	-0.81	2.02
			pre	66	2.91	0.82
			imm. post	66	2.62	0.75
			late post	66	2.72	0.76
		Pre-post	(trainee	23	-0.71	1.04
			(principal	43	-0.06	1.01
		Pre-late-post	trainee	23	-0.57	0.85
			principal	43	-0.11	0.81

All respondents $n = 89$.

Male = 46, Control = 22, Trainee = 23.

Female = 43, Principal = 44

Table 2. Comparisons post-test between trainees and principals

			No.	Mean	SD	P value
Confidence (q3 & q5)	Pre-post differences	trainee	23	-2.18	2.1	<0.05
		principal	43	-0.81	2.0	
Coping (q7)	Pre-post differences	trainee	23	-0.71	1.04	<0.05
		principal	43	-0.06	1.01	
	Pre-late post differences	trainee	23	-0.57	0.85	<0.05
		principal	43	-0.11	0.81	

The workshop made me more aware of the importance of active coping mechanisms, both for myself, and for my partners and colleagues.

Professional

Professional issues included specific areas related to an increase in knowledge and skill in the management of physical and psychosocial problems, the development of a different approach in that management, with increased confidence providing an overriding theme. Comments included:

Looking at individual symptoms rather than 'making comfortable' by sedation.

Changed approach—with concept of 'total pain' in that I am more likely to look into psychological/emotional causes of pain rather than just treating the somatic symptoms.

I feel more positive ... in my attitude towards treating symptoms in dying patients.

Less fear of patients who are dying/bereaved ...

Many comments suggested that responders' own knowledge and skill was acknowledged, and reinforced by sharing of experience and feelings both by participants and facilitators:

Awareness of difficulties that 'experts' have in coping and handling their problems, there I am more at ease with my own inadequacies'.

DISCUSSION

We have demonstrated that significant changes in self-perceptions of confidence and coping ability can result from a short workshop on palliative care. Immediate post-course evaluations may be useful in commenting on structure and process and, indeed, that is why this sort of evaluation is so commonplace. They cannot, however, predict any potential change in practice, and late evaluations such as those described here can be helpful in identifying either real or perceived changes in participants' approach to an area of practice.

Self-perceptions immediately after the course were of an increase in confidence and a perceived increase in effectiveness of coping mechanisms. Much of the content of the course concerned with physical and psychosocial problems was a reflection on participants' own knowledge and attitudes. Reinforcement, therefore, of their knowledge has produced an increase in confidence. There were those who rated their knowledge base lower after the course. This phenomenon can be demonstrated when

course participants' awareness of a lack of knowledge is highlighted during the course and is a predictable outcome on immediate post-testing. The shift is often reversed with later post-testing as was implied by the data here, suggesting an overall rise in confidence at the late post-test (Table 1d).

The greater shift demonstrated for trainees (Table 2) may indicate an immediate increase in knowledge but it could also be reinforcing the evidence that they learn in a different way to the principals (Newble & Entwistle, 1986; Pask, 1976).

The presentation of these results is inevitably only a small part in the evaluation of the process, but we believe that they demonstrate that such a course can stimulate change (in this case in confidence and the ability to cope with problems of death and dying) that may have an influence on an individual's practice.

In this study the questions concerning 'problem-solving' and the learning about coping mechanisms were included to give the course facilitators some framework to work in. It was not our intention to ensure that, for example, aspects of symptom management should be remedied by the use of a problem-solving approach. We hoped that participants would consider this method when approaching these areas of care following the course. Qualitative evaluations suggested that some had developed different approaches to the management of such problems and confirmed the quantitative findings that confidence had increased in this area.

It has been suggested that the fundamental outcome of education and training should be the enhanced proficiency of the adult learner, 'enhanced proficiency' being an increased capacity to perform effectively (Knox, 1982). The changes demonstrated were in confidence in dealing both with physical and psychosocial problems, and in the individual's perception of their ability to cope with these situations. It may be argued that this does not necessarily indicate an enhancement of proficiency, rather an enhanced awareness of proficiency, which may be considered of equal importance.

Participants' clearly identified elements of personal change in their coping and awareness of need for support. Responses suggested a feeling of safety within which such needs could be expressed. This strongly supported survey findings (MacLeod & Nash, 1991) regarding the need for personal issues to be addressed.

An issue that could usefully be addressed in future studies is the gender difference in personal coping ability when dealing with dying patients. One further area for future work could be review of the motivation for attending such a course—the evidence here suggesting

no significant difference in confidence in either physical or psychosocial areas between attenders and a control group.

In attempting to identify some change we chose self-rated confidence and coping ability as we believe that these are areas that can be reliably self-reported.

Validating such an instrument is potentially problematic, but by making qualitative assessments at the same time and only measuring individual changes rather than group changes, we feel that concurrent validity is established. Further studies will reinforce the reliability of such a test, but the addition of a qualitative element and the fact that these measures are self-rated encourage us to believe this to be a reliable method of evaluation.

CONCLUSION

This paper has described quantitative and qualitative methods of a largely experiential workshop in palliative care. Both personal and professional changes were identified after several months and the participants' perceptions of the effect of the experience on this practice noted. We have demonstrated significant changes in self-rated confidence in dealing with the physical and psychosocial problems of palliative care, and in course participants' perceived and reported ability to cope with dying patients and their families.

We have not investigated the motivation for attending such a course, but it may well be significant. Adult learners are strongly motivated to learn in areas relevant to their current personal development and also in areas that have proved problematic in their professional lives. It is widely acknowledged that motivating forces towards a professional interest in palliative care are often personal. It may be that by encouraging exploration of areas that have personal or professional significance we have stimulated an increase in confidence and a perception that individuals can cope more readily with areas of death and loss which, so often, have some personal significance for us all.

We have demonstrated here a significant latent learning effect. The presence of a continued shift in self-rated scores several months later implies that learning triggered by a particular course can continue for some time. It has been suggested that learning, particularly in attitude shifts, is not sustained after a course (Wilson Barnett, *et al.*, 1990). We believe that this trend can be affected by reinforcing existing knowledge and reflection on practice. It is important to continue to develop evaluation and assessment tools for all educational activities, to continue to refine courses according to results, and to develop our own awareness of effective teaching and learning techniques based on those results.

References

- Anderson J.L. (1982) Evaluation of a practical approach to teaching about communication with terminal cancer patients. *Medical Education*, 16, 202–207.
- Brookfield S.D. (1986) *Understanding and Facilitating Adult Learning*. Open University Press, Buckingham.
- Campbell D.T. & Stanley J.C. (1966) *Experimental and Quasi-experimental Designs for Research*. Houghton Mifflin, Boston.
- Coles C.R. (1989) *Effective Continuing Medical Education*. ASME Meeting, London, UK.
- Cronbach L.J. (1982) Issues in planning evaluations. In: Cronbach L.J. (ed.) *Designing Evaluations of Educational and Social Programs*. Jossey Bass, San Francisco.
- Doyle D. (1989) Education in palliative medicine and pain therapy. In: Twycross, R.G. (ed.) *Edinburgh Symposium on Pain Control and Medical Education*. RSM, London.
- Doyle D., Parry K.M. & Macfarlane R.G. (1982) Education in terminal care. *Journal of the Royal College of General Practice*, 32, 335–338.
- Field D. (1984) Formal instruction in United Kingdom medical schools about death and dying. *Medical Education*, 18, 429–434.
- Gale-Grant J. (1986) Theoretical issues in curriculum evaluation. In: Page, G. (ed.) *Essays on Curriculum Development and evaluation in Medicine* OCHS, Vancouver, Canada.
- Irwin W.G. (1989) Communication skills training for medical students: an integrated approach. *Medical Education* 23, 387–394.
- Knox A.B. (ed.) (1982) *Leadership strategies for meeting new challenges, New directions for continuing education*, No. 13. Jossey-Bass, San Francisco.
- MacLeod R.D. & Nash A. (1991) Teaching palliative care in general practice—a survey of educational needs and preferences. *Journal of Palliative Care*, 7, (4), 9–12.
- McGuire C. (1990) Program evaluation: self-indulgent luxury or basic necessity? In: Nooman, Z.M. *et al.* (eds), *Innovation in Medical Education*. Springer, New York, pp. 354–366.
- MacLeod R.D. & Nash A. (1992) 'Taking the lid off'—observations of the process of palliative care education for general practitioners. *Postgraduate Education for General Practice*, 3, 28–33.
- Maddocks I. & Donnell J. (1992) A Master's degree and graduate diploma in palliative care. *Palliative Medicine*, 6, 317–320.
- Mason C. & Fenton G. (1986) How successful is teaching on terminal care? *Medical Education*, 20, 342–348.
- Newble D.I. & Entwistle N.J. (1986) Learning styles and approaches: implications for medical education. *Medical Education*, 20, 162–175.
- Norusis M.J. (1988) *The SPSS Guide to Data Analysis for SPSS/PC+*. SPSS Inc. Chicago, Illinois.
- Pask G. (1976) Styles and strategies of learning. *British Journal of Educational Psychology* 46, 128–148.
- Schon D. (1987) *Educating the reflective practitioner, Towards a new design for teaching and learning in the professions*. Jossey-Bass, San Francisco.
- Thorpe G. (1991) Teaching palliative care to United Kingdom medical students. *Palliative Medicine*, 5, 6–11.
- Wergin J.F., Mazmanian P.E., Miller W.W., Papp K.K. & Loren Williams W. (1989) *Assessing the Impact of Continuing Medical Education Through Structured Physician Dialogue*. Centre for Education Development, Virginia.
- Wilson Barnett J., Corner J. & DeCarle B. (1990) Integrating nursing research and practice—the role of the researcher. *Journal of Advanced Nursing* 15, 615–621.

APPENDIX A

Self-rating scale: palliative care

Please mark a cross on the analogue scales, or in the boxes, where appropriate.

1. How satisfied are you that your handling of the physical aspects of different symptoms in dying patients is adequate? Completely satisfied 1————5 Not at all satisfied
2. Do you use a problem-solving approach to dealing with difficult symptoms? Always 1————5 Never
3. How confident are you when considering the principles of managing difficult symptoms in dying patients? Completely confident 1————5 Not at all confident
4. Have you experienced difficulty in coping personally with dying patients? Never 1————5 Always
5. How confident do you feel in dealing with difficult psychosocial problems when talking with dying patients? Completely confident 1————5 Not at all confident
6. Have you ever learned coping mechanisms during your training (undergraduate or postgraduate)? Yes ☐ No ☐
7. How effective do you feel your coping mechanisms are in helping you deal with the difficulties in caring for dying patients and their families? Completely effective 1————5 Not at all effective

Thank you for your co-operation in completing this questionnaire.

APPENDIX B

'Taking the lid off': A workshop for GPs. Evaluation form

8. Can you identify three aspects of your practice that have been affected by attending the workshop?
9. What, in the Workshop, did you find particularly helpful?
10. What did you find unhelpful?
11. We are considering the potential of a similar workshop aimed at the Practice Team, with an inter-disciplinary focus. Following your experience of the workshop would you consider this to be appropriate?

Thank you for your cooperation in completing this questionnaire.

Teaching holism in palliative care and hospice

Dr. R. D. MacLeod, MB, MRCP, MMed Ed

The history of the development of palliative care as a topic for inclusion in medical curricula is all too short. Despite the public recognition and awareness of palliative care as an important entity, the influential Todd report¹ in the UK in 1968 excluded any mention of teaching medical undergraduates about death and dying. The Wilkes report² for the Standing Medical Advisory Committee, in 1980, recommended that at least undergraduates should have some teaching in terminal care. The Association for Palliative Medicine (APM) of Great Britain and Ireland³ has written detailed guidelines for the teaching of doctors at all grades in palliative medicine and the General Medical Council in the UK⁴ has emphasized the importance of this subject by including it as a topic in the "core curriculum" for medical undergraduate teaching. Many other countries have also found a similar pattern of development is emerging.

Teaching "holism" in palliative care is fraught with difficulties. It is difficult in any discipline that espouses multidisciplinary approaches to care to estimate how well that discipline lends itself to analysis and division into its component topics, especially when that process of

care is promoted as being integrated and seamless.⁵

One of the difficulties that we face when considering the teaching of palliative care is how do we know what it is that we are supposed to teach? Indeed, is there an accepted view of what it is that we should teach?

*The Oxford Textbook of Palliative Medicine*⁶ has 18 chapters made up of 75 separate subheadings.

The palliative medicine curriculum of the APM³ subdivides its syllabus into:

Physical aspects - disease process

- symptom control
- pharmacology

Psychosocial aspects - family and social background

- communication skills
- psychological responses
- sexuality
- grief—awareness of professional and personal feelings

Religious and cultural aspects

Ethical aspects

Teamwork

Organizational aspects - statutory regulations

- practical support for the family

Non clinical issues - management

- research
- audit
- teaching

A definition prepared in the UK in 1987 when palliative medicine was adopted as a specialty reads: "palliative medicine is the study and the management of patients with active, progressive, far-advanced disease for whom the prognosis is limited and the focus of care is on quality of life."⁷

The WHO definition⁸ begins to cloud the issues: "the active total care of patients whose disease is not responsive to curative treatment; control of pain, of other symptoms and of psychological, social and spiritual problems is paramount. The goal of palliative care is achievement of the best quality of life for patients and their families. Many aspects of palliative care are also applicable earlier in the course of the illness in conjunction with anti-cancer treatment."

Part of the difficulty, then, is the division that is apparent right from the original definitions that we have elements of physical, psychological, social, and spiritual dimensions to symptoms and probably to other problems as well. From an early stage in our understanding of the specialty we are encouraged to pick it

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Table 1. (from Twycross, R.G. & Lack, S.A., 1983, *Symptom control in far advanced cancer*)

Total pain	
Physical	Spiritual unrest
<ul style="list-style-type: none"> • Debility • Therapy side effects • Non cancer pathology • Cancer 	<ul style="list-style-type: none"> • Hopelessness • Guilt • Lack of understanding
Sadness	Anger
<ul style="list-style-type: none"> • Loss <ul style="list-style-type: none"> • of independence • of future • of roles • Chronic fatigue & insomnia • Helplessness • Disfigurement 	<ul style="list-style-type: none"> • Bureaucratic bungling • Delays in diagnosis & therapy • Unavailable doctors • Therapeutic failure
Anxiety	Anxiety
<ul style="list-style-type: none"> • Fear <ul style="list-style-type: none"> • of dying • of pain or suffering • of death • Loss of dignity 	<ul style="list-style-type: none"> • Worry <ul style="list-style-type: none"> • about family • about finances • about future

apart. This is compounded by the way that palliative medicine at least is taught. As illustrated by the APM syllabus, everything is dissected into its component parts. That's the way that medical education has always been!

Reviewing much of the published work on what is actually being taught, emphasis is placed on this division. Anthony Smith has provided useful information on activity in the UK medical schools⁹ and more recently David Field has reported on all activity in UK medical schools that has any teaching about death, dying, and bereavement in any setting.¹⁰ Field's work shows a broad variation in activities and aspects ad-

dressed in the teaching of this subject. He also shows us that there is now a broader range of disciplines involved in the teaching. From the information provided it is seen that much of the teaching still revolves around the old favorite of medical teachers—the lecture; but over the last 11 years at least there has been some change, hopefully for the better! He addresses some of the deficits in the areas of evaluation that Chris James and Rod MacLeod identified three years ago.¹¹ Little systematic evaluation of the effectiveness of teaching in this area in UK medical schools at least has been done. Some of the work that has been done in North America has looked at the affective

changes that have taken place in the learner¹² and MacLeod's work is similar although he looked at confidence ratings as well in GP trainees and principals and the differences in their learning.¹³ Durlak and Reisenberg suggest that "experiential" learning and teaching are more effective at altering student attitudes and reducing personal fears about death¹⁴—a phenomenon that was noted in the work of Rod MacLeod and Ann Nash in the UK some years ago.¹³

There is more light at the end of the tunnel and the development of problem based learning and a change in the way that we acknowledge different learning styles and strategies means that perhaps this dissection will be less needed. Learning in medical schools and, to a lesser extent, in postgraduate courses has focused on separate issues within the boundaries of palliative care and part of this paper will be to attempt to review the need or the wisdom in doing this.

Cicely Saunders wrote in 1992;

"Those working in the field have the responsibility not only for carrying out their practice but also for making it better known. We not only have to work continually on our professional standards but also to spread the knowledge that already exists."¹⁵

Part of the difficulty is that we can't always be sure that we know what it is that we do. We are certainly less clear about how it is that we do it.

Chris James and Rod MacLeod explored some of these issues after a multidisciplinary workshop looking at teaching and learning in palliative care.⁵ Much of the discussion is outlined in that small publication and some of the areas of interest are noted.

If we are going to be successful in our teaching then it is likely that we will have to achieve a balance between content and process—"the knowing what" and "the knowing how." We need, as teachers, to identify which domains of professional practice are the most important. Is it the technical, the practical, the moral/ethical,

the social/political/economic or the personal? Some of the questions asked at that time were related to the difficulty in conceptualizing palliative care itself.

What exactly are the constituent parts of palliative care?

How discrete are the various elements and what might we lose from the whole by desegregating them?

Essentially the most pertinent question is how do we communicate what it is like in the lifeworld of palliative care to someone who has no concept of what that lifeworld may be?

This question is further complicated by the fact that my view from that lifeworld may be entirely different from yours. Is there an accepted view of what palliative care is?

Is it an Australian view or an American view or a European view? Or perhaps they are all the same. How, then, do we approach the teaching of palliative care? Surely the answer will be to have options and differing approaches.

One of the first tasks for teachers in this area is to identify with the learners what their needs are. In medical education, at least, there is often a suspicion that the learners don't actually know anything until we teach it. The breadth and personal dimensions of palliative care mean that all the people who come to this area of study will bring with them some personal and professional knowledge. We must decide how we will encourage this to influence their learning and inevitably their practice.

Look at pain as an example (Table 1). These dimensions—physical, psychological, spiritual and social—can further be divided and a new composite picture will be elicited. If we draw on the personal aspects of pain and try to connect the learner with some of the aspects which will be relevant to that learner, then perhaps we will be more successful at engaging them and helping them to learn what it is to experience pain.

If we now move aside and look at

Table 2. (from Eric Cassell, *The nature of suffering*)

- a person has a past
- a person has life experiences
- a person has a family/kin
- a person has roles (there is no self without others)
- a person has a body
- a person has a secret life
- a person has a perceived future
- a person has a transcendent dimension

suffering, we can once again see that by relating it to our own lifeworld and what that means then we can engage the learner and help them to reflect on what suffering may be and how it might affect an individual. Part of the act of teaching "holism" needs to be the encouragement of the concept of reflection in action.¹⁶ The reflective art of practice is the elemental structure of self-directed learning.

This list of components of "self" (Table 2) is taken from the work of Eric Cassell¹⁷ and can be usefully employed to identify some of the difficulties in dealing with pain or other difficult symptoms that lead to suffering.

In the teaching of palliative care we have to consciously try at times to get away from the medical model. We have to realize that so much of what is happening to people cannot be "fixed" in the classical medical way. That approach will threaten the process of socialization that doctors have been through where they are first led to believe that there is much that is similar in all individuals and that most of medicine is geared to fixing things or making them better. Maybe we should not be talking about symptom control (encouraging the fix-it attitude) but symptom alleviation or amelioration! When teaching about the care of dying people, it is essential for us at least to attempt to identify what the needs of the learners might be. Clearly, there will be

certain factual information that is essential, but many of the other needs that these learners might have must be identified, first by the learners, and at least recognized by the teachers. Do we know what personal knowledge they all bring with them? Do we know how that personal knowledge or experience will influence their learning or perhaps what barriers to learning may exist because of that lifeworld that we know so little about?

It has been suggested by at least one group of researchers, that the family events of medical learners may present educators with "teachable events;" junctures at which the right kind of help may prevent future dilemmas.¹⁸ Triggering events provide a window of high motivation to learn and change. This concept fits well with the understanding that continuing medical education (CME), at least, should be practice based; contextual learning should be probed and facilitated, and that learning should be introduced into the everyday environment.

Wergin *et al*¹⁹ indicated that change attributable to CME was often subtle and delayed—a phenomenon that MacLeod and Nash's work in teaching palliative care in the UK suggested. Educational experiences are complemented by other sources of information both before and after changes are made.

In their report of a large study into

physician learning, Fox²⁰ and his co-workers identified four types of change:

- accommodation
- adjustment
- redirection
- transformation

The latter type of change was often complex, involving many relationships and accompanied by very strong, normally positive emotions. They implied that there needed to be a restructuring and redefinition of many elements of the physicians' personal and professional lives. It seems unlikely that some of the elements of change that we would hope to see following our educational activities in this area would follow if we dissect the constituent parts of our practice before teaching as some of the curricula suggest.

Where do we start the education process?

The arguments just stated are well illustrated if we look at the teaching or learning of empathy. Here is an area of practice, if you like, that doesn't appear in any curriculum as far as I know and certainly doesn't appear in the documents that are referred to in this paper.

Howard Spiro has written that "empathy helps us to know who we are and what we feel."²¹ During medical education "first we teach the students science and then we teach them detachment." He talks of the abuse of our students and their subsequent learning to care less for people and more for themselves.

In this multidisciplinary discipline we have much to learn from nurses. Nursing theorists define nursing with reference to the principle of care. "Nurses observe, listen, test, assess, diagnose, monitor, manage, treat and cure. But above all nursing is caring." Professional knowledge—for nurses—comes from caring ... "nursing, practically alone among the human service professions, deliberately tries to train its young in empathy, sensitivity, and compassion."²²

It has been suggested that the effective

use of empathy can, and should, be taught. When used in a professional way, it becomes more consistently effective, more versatile and more penetrating. With discipline, empathy or "empathic understanding" becomes a fully reputable scientific technique.

"Conversation helps to develop empathy."²³

Perhaps this is what we are aiming at in our teaching in this area when we encourage students spending time at the hospice to sit and talk with people who are dying—not to elicit the all too familiar medical history but to find out what it is that makes that person who they are. What are their stories? What are their hopes? What are their fears? What are the elements of their personhood?

If we look to the Hippocratic Oath for some guidance it becomes apparent that we may be doing things a little wrong in this area of education in medicine. That oath talks of the student-teacher relationship in terms of family: "to hold my teacher in this art equal to my own parents...."

Physicians believe the principle goal of this relationship is to impart knowledge and much of the teaching in palliative care is about imparting knowledge. How this is done seems less important than the fact that it is done. Stanley Joel Reiser suggests that this approach is short sighted.²⁴ He contends that how students are treated is as important as the technical facts imparted to them. Hippocratic physicians would never impart technical knowledge disconnected from a relational context.

He asks if we can afford to ignore the attitudes unwittingly instilled in medical students by instructors who have not recognized that there is a relationship between the way they treat medical students and the way those students will treat their patients. Some of these teachers (and I suppose that includes us) have been termed "educational influentials." We should think of ourselves as "change assistants" and we should ensure that all who might be seen as "educational influ-

entials" are trained in the most appropriate techniques to help them in this act.

Physicians often see emotional attachment to patients as too burdensome and time consuming. This attachment takes its toll and one way that physicians have been able to deal with this is to develop the principal of "detached concern." They will often compartmentalize things so that individuality is removed and therefore becomes less of a problem. This compartmentalization comes through in their teaching as well as their practice. This ideal of "detached concern" represents the hope that the goals of objectivity, reliability, and caring for patients are all compatible.

There are many other areas of practice that might also have an influence on how we care for people who are dying. Spiro suggests that we should be concerned with mind and spirit in being human as well as being sick.²¹ The practice of palliative care addresses some of those areas. So, too, does it address some of the social and economic forces that influence health and well-being, but perhaps we should be more aware of the social sciences and anthropology as well as philosophy and religion in our search for the teaching of holistic care. These are areas of interest that will broaden our understanding of suffering and illness and so perhaps will in turn help us to care for people who are dying and their families.

I would like to feel that by developing our understanding and, therefore, our ability to teach "holism," we would aim to achieve the four goals that Fox and co-workers set out in their report:²⁰

- a sense of personal commitment to changing practice;
- a lengthy change process involving multiple experiences;
- an opportunity to develop concepts that will eventually ungrid medical practice;
- an opportunity to deliberate over information instrumental to these new elements in life or practice.

When we try to pass on what we know and how we practice it, we will gain a deeper understanding of the nature of life and perhaps the nature of death, and maybe we will understand what it means to teach about the care of the dying.

(Note: This paper is based on a presentation given at the International Institute of Hospice Studies Inaugural National Conference "Teaching Care in Cooperation" held in Adelaide, South Australia, April 19-21, 1996.)

References

1. Royal Commission on Medical Education: HMSO, London, 1968.
2. Standing Medical Advisory Committee: Report of the working group on terminal care (Wilkes Report). Standing Medical Advisory Committee, London, 1980.
3. Association for Palliative Medicine of Great Britain and Ireland: Palliative Medicine Curriculum. APMGBI, Southampton, 1993.
4. General Medical Council: Tomorrow's Doctors: Recommendations on undergraduate medical education. GMC, London, 1993.
5. MacLeod RD, James CR: (eds) *Teaching and Learning in Palliative Care—Issues and Implications*. Patten Press, Penzance, Cornwall, 1993.
6. Doyle D, Hanks G & MacDonald N: (eds) *Oxford Textbook of Palliative Medicine*. Oxford University Press, Oxford, 1993.
7. Ford G: Specialist medical training in the United Kingdom. *Palliative Medicine*. 1988; 5:147-152.
8. World Health Organization. *Cancer pain relief and palliative care: Technical report series 804*. Geneva: World Health Organization, 1990.
9. Smith AM: Palliative medicine education for medical students: A survey of British medical schools, 1992. *Medical Education*. 1994; 28:197-9.
10. Field D: Education for Palliative Care. *Medical Education*. 1995; 29:414-419.
11. James CR & MacLeod RD: The problematic nature of education in palliative care. *Journal of Palliative Care*. 1993; 9:4-10.
12. Lloyd JS & Abrahamson S: The effectiveness of continuing medical education: A review of the evidence. *Evaluation and the Health Professions*. 1979; 2:251-280.
13. MacLeod RD, Nash A & Charny M: Evaluating palliative care education. *European Journal of Cancer Care*. 1994; 3:163-168.
14. Durlak JA & Reisenberg LA: The impact of death education. *Death Studies*. 1991; 15:39-58.
15. Saunders C: Voluntary euthanasia. *Palliative Medicine*. 1992; 6:1-5.
16. Schon DA: *The Reflective Practitioner*. Basic Books, New York, 1983.
17. Cassell EJ: *The Nature of Suffering and the Goals of Medicine*. Oxford Univ. Press, Oxford, 1991.
18. Parochka J & Fox RD: Family and community; in Fox RD, et al: *Changing and Learning in the Lives of Physicians*. Praeger, New York, 1989.
19. Wergin JF et al: CME and change in practice: An alternative perspective. *Journal of Continuing Education in the Health Professions*. 1988; 8:147-159.
20. Fox RD, Mazmanian PE, Putnam RW:(eds) *Changing and Learning in the Lives of Physicians*. Praeger, New York, 1989.
21. Spiro H, McCrea Cumen MG, Peschel E, St James D: *Empathy and the Practice of Medicine*. Yale Univ. Press, London, 1993.
22. Diers D: To profess to be a professional. In *Nursing trends and issues*. ed C. Lindeman and M. McAthie. Springhouse, Penn.: Springhouse, 1990.
23. Spiro H: What is empathy; can it be taught? in Spiro H et al (eds) *Empathy and the Practice of Medicine*. Yale Univ. Press, London, 1993:9.
24. Reiser SJ: Science, Pedagogy and Empathy in Spiro H et al (eds) *Empathy and the Practice of Medicine*. Yale Univ Press, London, 1993:126.

Improving the effectiveness of palliative care education

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Key words: education, medical; evaluation studies; models, educational; palliative care

Over the last three decades palliative care has emerged as a discrete specialty that has brought with it a developing field of education. Problematic areas have been identified within palliative care education that may limit its effectiveness. Areas of particular concern are identified that may prove obstructive in the pursuit of effectiveness in palliative care education. The possibility of developing performance indicators is explored with reference to the development of such indicators in other areas of education. Proposals are made as a starting point for the evolution of such indicators.

Mots clés: formation, médical; études d'évaluation; modèle, instructif; soins palliatifs

Pendant les trente dernières années les soins palliatifs ont apparu comme une spécialité discrète qui comportait un domaine de formation en évolution. Des domaines problématiques ont été identifiés dans la formation en soins palliatifs qui peuvent limiter son efficacité. On identifie les domaines d'intérêts particuliers qui peuvent enrayer la recherche d'efficacité dans la formation en soins palliatifs. On explore la possibilité de développer des indicateurs de performance concernant le développement de tels indicateurs dans d'autres domaines de formation. On fait des propositions pour le point de départ d'évolution de tels indicateurs.

Introduction

The development of palliative care as an identifiable specialty has meant that many areas of care have been re-examined and consequently some aspects of education in those areas will need to be reviewed. A number of indicators, for example, world-wide increases in the age structure of populations, the rising incidence of cancer and the world-wide spread of HIV/AIDS, point to an increase in the need for

palliative care in the coming years. As the need for palliative care increases so does the need for palliative care education. For a variety of reasons, not least of which is the requirement for efficient use of resources, there are increasing demands for effectiveness in this form of education. Meeting those needs is particularly challenging because the nature of palliative care means that teaching and learning about it are complex and problematic.¹ The purpose of this paper is to review some of those problematic areas in order to explore ways of improving the effectiveness of teaching and learning in palliative care.

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The breadth of education in palliative care

Throughout the world there is wide variation in palliative care education. The European Association for Palliative Care has surveyed the current status of professional education in this discipline in Europe² and others have attempted broader reviews.^{3,4} Palliative medicine curricula have been written and adopted in the UK, Canada and all member states of the European Union, which embrace not only undergraduate but also post-graduate and higher professional training. Work continues on curricula for nursing education in many parts of the world. Formal education programmes have been developed both in Australia⁵ and in the UK and plans for further expansions are in progress. Higher professional training in palliative medicine has been available in the UK for some years and there are currently numerous training posts in that country.

Increasing effectiveness in palliative care education: some problematic areas

James and MacLeod^{1,6} have previously identified areas that may be problematic in the field of education in palliative care. These included:

- palliation as an emerging field of care;
- an inadequate definition of the field of care;
- palliative care as a new specialty;
- the difficult relationship between palliative care and palliative medicine;
- the problem of identifying a good palliative carer;
- individual expertise and teamwork in palliative care;
- the emotional and psychological demands of palliative care;
- the wide range of settings for palliative care.

To this list could be added the problems of distance, cost and access to effective programmes of education. Some of these issues have been clarified by recent publications (e.g. Doyle *et al.*⁷). Although welcome as contributions to the debate, such frameworks and outlines for practice still leave the educator with very challenging decisions to make about how to put such guidelines into practice.

The use of the term effectiveness in education causes difficulties. The term itself implies that the purpose of an educational act or process is clear and that since the outcome is predetermined, it is then possible to measure its effectiveness. Unfortunately, only very few aspects of palliative care education lend themselves to such a technical approach. In the main, much of this palliative care knowledge is in a different form. It lies in the hermeneutic/interpretive domain (where establishing the meaning of phenomena is essential), in the moral-ethical domain or in the personal domain. In addition, these aspects are, for the reasons outlined above, problematic and lacking in universally accepted unequivocal support. For these reasons, the central question for palliative care educators becomes 'How can we attempt to achieve effectiveness when it is not clear what we are trying to effect?' There is a risk that such is the drive to achieve measurable quality that this question may be side-stepped. Two possible dangers could result from this simplistic approach.

One danger is that this simplification could lead to a technologizing of palliative care education. This mechanistic approach would deny the complexity of palliative care education and view it as a set of particular instrumental responses to a requirement to learn about the different aspects of palliative care. Such an approach sees palliative care education as providing discrete answers to practice problems. This problem-solving view of teaching and learning where teaching is designed to achieve a set of predetermined behavioural objectives is not an appropriate one in this context. It would fail to do justice to the holistic character of palliative care with its multiplicity of interrelated, interconnected and dynamic facets of a personal, technical, practical, moral, social, cultural, emotional and spiritual kind. That is not to say that educational activities in palliative care must inevitably be aimless; they should have intentions and purposes. It is simply recognizing that the complexity of many aspects of palliative care make it impossible to predict and specify the nature of the educational outcomes in any prescriptive way. Neither is this criticism of mechanistic approaches intended to undervalue the teaching of basic skills essential in palliative care such as the use of a problem-solving approach, assessment and listening that are measurable to some degree. Such basic skill development will

always be an important part of palliative care education.

A second danger which could arise from a simplistic approach to palliative care education is that it could lead to a response to meeting the needs of learners in palliative care in which teaching is founded on a deficit model. Such a response would be characterized by a reliance on didactic approaches which sought to transmit the knowledge of those 'who know about palliative care' to those 'who do not know' or by an overemphasis on learning objectives which promote a depersonalized and technical view of palliative care. Simplistic approaches to palliative care education are not appropriate. We would assert that this area of care is best characterized by forms of knowledge that are personal and shared, which seek to reveal meaning through interpretation and which have moral and spiritual dimensions. This implies that a more therapeutic learning environment needs to be created or facilitated and more emphasis placed on ownership and accountability from the learners. Measuring effectiveness in these domains of knowledge is notoriously difficult. The practice of adopting a 'jug and mug' approach to education so loved by medical teachers is still widespread. A survey of medical teachers in hospice programmes⁸ found that didactic approaches still predominate, with 66% of topics being taught by lecture. The idea is, perhaps, that by providing 'tips and tricks' for the learners, those teaching in this way may consider themselves to be efficient because they are able to test the knowledge acquired by these means fairly readily. This criticism of lectures is not saying that aspects of palliative care cannot be represented by factual knowledge in propositional form. It is, however, asserting that palliative care is best characterized by other forms of knowledge such as those outlined above, a point emphasized by Sheldon and Smith.¹⁰ Achieving effectiveness in these forms of practice and education requires teachers to be reflective practitioners capable of reflecting both in and on their practice.¹⁰ Reflective practice remains a robust model of professional action although it has been challenged. For example, Eraut¹¹ has criticized it for its dismissal of technical rationalist approaches and Fenstermacher¹² has called into question the narrow range of cases on which Schon bases his assertions. Van Manen¹³ has sought to extend the modes of reflection, stressing the importance of reflection before

action and 'stop and think' reflection when action is suspended for reflection to take place. Eraut¹¹ has sought to separate out the purpose of reflection, stressing the importance of reflection for action. Clarke *et al.*¹⁴ have emphasized the importance of reflection in action in professional action and as a focus for research to redress a shift in emphasis towards reflection on action in the discussion and debate about the nature of reflective practice. They have also stressed two kinds of reflection for professional practitioners: deliberative reflection which takes place within the accepted norms of practice and deep reflection which seeks to extend the bounds of accepted practice. The importance of reflective practice for educators in palliative care is that by reflecting in and on action they will, perhaps, develop their own understanding of palliative care and may move towards being able to facilitate the development of that knowledge by others. By reflecting on their own experience, practitioners and educators can facilitate reflection by others (the learners) and so enable some self-recognition of effectiveness. Attempts have been made at measuring effectiveness in such areas as the ability to cope with stressful situations or self-perceptions of confidence in dealing with physical or psycho-social aspects of care following a course designed for principals and trainees in general practice¹⁵ as measured by changes in self-rating scales for these items.

The issue of effectiveness is made more difficult by changes in philosophy or emphasis within clinical care. The urgent need to control pain and other distressing symptoms effectively can shift the emphasis of the specialty from dying to palliation and for some this has reinforced the need for a medical approach. Such a view of palliative care devalues the broader and, from an educational point of view, more problematic vision of the task of caring for people who are dying. It also has the potential to develop mechanistic and simplistic responses to palliative care education.

However, there is a possibility that in being sensitive to these dangers in the provision of palliative care education and being overcautious about measures of effectiveness, palliative care education is seen as practically beyond evaluation. It is seen almost as being:

- too complex to evaluate, so wide-ranging are its different purposes, processes and content;

- too precious to evaluate, so personal and intimate are the nature and outcomes;
- too problematic to evaluate, so unclear is the nature of palliative care learning;
- too difficult to evaluate, so uncertain and unpredictable are the outcomes of palliative care education.

Performance indicators

Despite the difficulties encountered in evaluating education in palliative care, those involved do have a responsibility to ensure that as far as possible that education is effective and appropriate. Evaluation can give insight and we suggest that performance indicators, refashioned into an appropriate form for palliative care, may be helpful in that evaluation process. Three particular aspects of the use of indicators need to be considered if such indicators are to be helpful.

First, although performance indicators can be used as measures, typically quantitative ones, of performance against preset objectives, there is general agreement that in education, performance indicators should be seen as indicating, signalling and guiding performance rather than as categorical, absolute and definitive measures of performance. They should be viewed as statements against which achievement in an area or activity can be assessed^{16,17} and therefore are very likely to be qualitative in nature. If performance indicators are to be used in palliative care education, it is essential that they be seen as indicators rather than as measures of absolute standards. (To use them as absolute measures would encourage mechanistic and simplistic approaches to palliative care education.) In practice, the indicators could perhaps be best used in a group discussion to frame the responses of the learners and to provide rich and illuminating qualitative indications of the learners' experience. This approach would be most useful at an individual problem/issue level and comparison between programmes, for example, could be difficult. It has to be said, however, that such is the variation in any palliative care education that comparisons between programmes will always be difficult. The performance indicators could also help to frame responses in student feedback questionnaires used in the evaluation of many palliative care education programmes.

Secondly, the focus of the indicators must be broader than simplistic measures of outcome: they must embrace inputs, processes and outcomes of educational practice.¹⁸ All three aspects of educational practice are of value and it is quite likely that input and process indicators will be a more helpful gauge of value than outcome indicators. Developing tools to evaluate, for example, lectures, group work, independent work, practical experience, tutorial support or the overall programme organization will also be useful. Other activities which support and enrich learning (for example, library facilities, rest-rooms and social activities) should also be evaluated.

Thirdly, the way that performance indicators are constructed needs to be considered. For example, in the UK, in 1987 the then Department of Education published guidelines for establishing performance indicators.¹⁹ In essence, these guidelines suggested that performance indicators must:

- relate to the stated objectives of the organization;
- be as simple and as few in number as possible;
- be acceptable and credible to those concerned;
- be capable of acting as signposts to key areas where questions concerning operations can and should be asked;
- be specific, quantifiable and standardized.

This set of guidelines may provide a starting point for the development of performance indicators in palliative care education. So, using these guidelines, we suggest the following guiding principles for the development of such indicators.

Guiding principles for the development of performance indicators for palliative care education

- 1) Performance indicators must be consistent with the values, beliefs, ethos and purpose of the organization where the educational activity is taking place. Further to that, indicators of performance must be consistent with the nature and purpose of palliative care itself. An example might be that the educational activity encourages the exploration of dimensions of care that embrace some ethical principles of health care (e.g. justice, veracity, autonomy, beneficence).

- 2) Performance indicators must be simple and relatively few in number. This will help to ensure that their meaning can be grasped by all those involved in the educational process. Simple indicators are likely to reveal as much as more complex and elaborate ones and are often more appropriate because they can be more penetrating in terms of revealing information. The case for simplicity is strengthened because the evaluation process is not simply addressing output measures but input, process and outcome measures at a level of appropriateness.
- 3) Performance indicators should be acceptable to all those concerned in terms of the performance indicators' credibility, appropriateness and relevance to their practice of palliative care and the values that underpin it. To achieve this acceptance, those involved in the educational activity should participate in the specification of the indicators. This has the added benefit of ensuring that the creation of the indicators becomes a development activity in its own right. Involvement of the learners in formulating those indicators may increase active engagement in the learning and promote learner autonomy. Despite the recognition and importance of self and peer review there is little evidence to suggest that these practices are widespread in the caring professions.²⁰ The creation of a learning environment where these processes are fostered could be seen in itself as a performance indicator for those developing a programme.
- 4) Performance indicators should act as signposts, guiding educational practice rather than as benchmarks or standards to be attained. Such is the uncertainty of the process of education in palliative care that defined standards are not likely to be of use in promoting the improvement of practice. Negative performance indicators or elements of practice which should not occur may be of particular value.
- 5) Performance indicators should be specific in that they should focus on the development of learning, in particular that learning which influences practice. However, it is not appropriate for such indicators necessarily to be quantifiable and standardized. Many aspects of palliative care are susceptible to neither quantitative analysis nor standardization since many of the data will be subjective and personal and will be concerned

with higher order outcomes. Evidence from the way in which physicians learn, for example, suggests that forces for change take the form of personal, professional and social forces or combinations of these forces.²¹ There will be performance indicators where evidence will be collected in the cognitive domain (for example, is the pharmacological knowledge of the learners increased?) but there may also be evidence of aspects of knowledge of a physical and emotional kind which may not be measurable objectively. There will be indicators where the evidence will be of a personal nature concerned with an individual's self-awareness, insight and personal understanding. There will be performance indicators that are concerned with the development of processes, particularly higher order ones, in individuals. These might be concerned with developing new ways of thinking or with the development of metacognition or reflective processes. Although performance indicators should relate to features that are observable,²² it has to be recognized that this may not be possible in palliative care education. It is quite possible for outcomes in palliative care education not to be immediately observable. For example, the outcome of enhanced self-awareness may not be observable except by the individuals themselves and the ability to reflect at a deeper level may not be apparent in an individual's practice.

Writers such as Schon⁹ and Nowlen²² acknowledge the importance of theoretical bases for knowledge but also point to other dimensions such as cultural influences, professional meaning and the 'art' of practice as guided by 'the inner voice'. These components should all act in concert in practice as well as in the educational process but the latter dimensions may not lend themselves readily to the development of performance indicators.

Theoretical bases for knowledge are becoming well established but one of the difficulties faced in palliative care and therefore in palliative care education is an apparent reluctance to make judgments or even observations about the practice of others. Until we can feel comfortable in that area we are in danger of reducing our practice to mere caretaking and minimizing the professional nature of both palliative care and palliative care education. Participation in the shared development of perfor-

mance indicators in the way we have suggested may reduce the anxiety and discomfort associated with making judgements about educational practice.

Conclusion

This paper has identified and reviewed some of the issues surrounding the concept of effectiveness in palliative care education. It has proposed the use of performance indicators as a way of assisting with the difficult task of evaluating palliative care education and establishing its effectiveness and appropriateness. The paper has outlined some considerations and guiding principles for the development of performance indicators in palliative care education. What is now required is further research into the development and use of indicators, particularly in the form of case studies of educational practice. The sharing of such research will help to improve the quality of education in a highly complex and challenging area.

References

- 1 James CR, MacLeod RD. The problematic nature of education in palliative care. *J Palliat Care* 1993; 9(4): 5–10.
- 2 Doyle D ed. *Survey on the current status of professional education in palliative care*. Geneva: EAPC, 1992.
- 3 Billings A. Medical education for hospice care; a selected bibliography with brief annotations. *Hospice J* 1993; 9: 69–83.
- 4 MacLeod RD. Education in palliative medicine: a review. *J Cancer Educ* 1994; 8: 309–12.
- 5 Maddocks I, Donnell J. A masters degree and graduate diploma in palliative care. *Palliat Med* 1992; 6: 317–21.
- 6 MacLeod RD, James CR eds. *Teaching palliative care: issues and implications*. Cornwall: Patten Press, 1994.
- 7 Doyle D, Ford G, Webb P, Sheldon F, Murray D. *Working party on education and palliative care*. London: National Council for Hospice and Specialist Palliative Care Services, 1996.
- 8 MacLeod RD. Teaching postgraduate palliative medicine. Master of Medical Education thesis, University of Dundee, 1992.
- 9 Schon DA. *The reflective practitioner: how professionals think in action*. New York: Basic Books, 1983.
- 10 Sheldon F, Smith P. The life so short, the craft so hard to learn: a model for post-basic education in palliative care. *Palliat Med* 1996; 10: 163–64.
- 11 Eraut M. Schon schock: a case for reframing reflection in action. *Teachers Teaching* 1995; 1: 9–22.
- 12 Fenstermacher GD. The place of science and epistemology in Schon's conception of Reflective Practice. In: Grimmer PP, Erickson GL eds. *Reflection in teacher education*. New York: Teachers' College Press, 1988.
- 13 Van Manen M. *The tact of teaching: the meaning of pedagogical thoughtfulness*. New York: State University of New York Press, 1991.
- 14 Clarke B, James C, Kelly J. Reflective practice; reviewing and refocussing the debate. *Int J Nurs Stud* 1996; 33: 171–80.
- 15 MacLeod RD, Nash A, Charny M. Evaluating palliative care education. *Eur J Cancer Care* 1994; 3: 163–68.
- 16 Hopkins D, Leask M. Performance indicators and school development. *School Organisation* 1989; 9: 3–17.
- 17 CNA. *Towards an educational audit*. London: Council for National Academic Awards, 1989.
- 18 OECD. *Innovation in education. The search for educational indicators*. Paris: OECD News, 1988.
- 19 DES. School indicators – a discussion paper (mimeo) circulated Spring 1988. Cited in: Hopkins D, Leask M. Performance indicators and school development. *School Organisation* 1989; 9: 3–17.
- 20 Jennett P. Lifelong self-directed learning. In: Coles C, Holm HA eds. *Learning in medicine*. Oslo: Scandinavian University Press, 1993.
- 21 Fox RD, Mazmanian PE, Putman RW. *Changing and learning in the lives of physicians*. New York: Praeger, 1989.
- 22 Nowlen PM. *A new approach to continuing education for business and the professions: the performance model*. New York: Macmillan, 1988.

LEARNING/TEACHING

Teaching about Living and Dying: Medical Undergraduate Palliative Care Education in Wellington, New Zealand

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ABSTRACT *Context:* Palliative medicine education has been undertaken in a number of clinical schools for over 20 years, but systematic education in this subject area is still not common. During the last five years at the Mary Potter Hospice, Wellington, New Zealand, in partnership with the University of Otago, Wellington School of Medicine, we have been developing a longitudinal experience for our students.

Goal: *In this paper we summarise our experiences with the intention of providing some ideas and guidance for schools that have not yet begun including this important area in their regular curriculum.*

Approach: *In each of their clinical years, students have an opportunity to explore aspects of the care of people who are dying. Didactic learning in the classroom is reinforced by clinical exposure in the hospice in-patient unit.*

Findings: *Students state that their confidence in providing palliative care and their ability to communicate with people who are dying are improved and that they would value more exposure to this aspect of medical practice. This programme provides an opportunity for a closer liaison between the hospice and the University. More formal links are being developed.*

Introduction

A report of the US Institute of Medicine (Field & Cassel, 1997) states that “humane care for those approaching death is a social obligation as well as a personal offering from those directly involved.”

The teaching of basic palliative care in undergraduate schools in Australasia is uneven. In 1997 the majority of schools in Australasia endorsed the Under-

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For a commentary on this paper, see pages 193–194

graduate Medical Palliative Care Curriculum of the Australia and New Zealand Society of Palliative Medicine (ANZSPM). An objective of the ANZSPM curriculum is to help standardise the coverage of core topics and address the processes of learning that might be adopted. A further objective is "to promote a learning experience which permits students to develop the attitude, knowledge and skill base required for them to participate in effective and compassionate palliative care."

Some teaching in areas directly related to the care of people who are dying has gone on for many years. However, when palliative medicine became a discrete specialty, it was felt that a more concerted approach to teaching should be adopted.

The Mary Potter Hospice has been a provider of specialist palliative care services in Wellington, New Zealand since it opened in 1979. Current services include a 22-bed inpatient unit staffed by medical and nursing staff, occupational and physical therapists, a complementary therapy coordinator, counselors, social workers and volunteers. The service includes outpatient facilities, education and research programs. Over the last decade, the clinical teaching program of the University of Otago, Wellington School of Medicine has given increasing attention to palliative care. In the last three years the amount of time devoted explicitly to palliative care has been increased, and the teaching of medical students by a multi-professional team at Mary Potter Hospice has expanded. Until 1994, teaching in this field was offered only to final year students.

One medical, one nursing and two counseling personnel now teach palliative care on a regular basis. Only one of them (RDM), however, holds an appointment with the faculty of the medical school. The team members meet regularly to reflect on the processes and outcomes of their teaching and to revise their approaches in response to feedback from other clinical teachers at the school.

Since Mary Potter Hospice opened, hospice staff has taught medical students. For six years there has been liaison between the hospice and the Department of Psychological Medicine. Starting in 1991, during their General Medicine rotation, trainee interns (sixth year students) have been attached to the hospice. A recent development is the inclusion of palliative medicine in the Department of Surgery's teaching of fourth year students in their early clinical training. Throughout pre-clinical and clinical training, a more generalist approach to palliative care is addressed by other faculty members in the Departments of Oncology, General Practice, Psychological Medicine, General Surgery and General Medicine.

The hospice teaching is focused on encouraging the students to develop a more reflective approach to their care of people who are dying.

Content

The development of experiential teaching styles in our program has been influenced by work undertaken previously in palliative care education and

reported elsewhere (MacLeod & Nash, 1992, 1994). In this program opportunities are provided for students to gain a broad understanding of palliative care and guidance is offered in dealing with difficult issues when caring for people who are dying. The current areas of involvement of educational activity are outlined below.

Fourth Year

During the last two academic years three hours of seminars in two sessions have been arranged at the start of each surgical attachment. Students attend in groups of ten to twelve (there being five or six groups in total). These sessions are to introduce the students to the principles and practice of palliative care, including the social and psychological needs of people who are dying and their families. The focus is on person-centered care and the importance of working in a multi-disciplinary team. Concepts of best clinical practices are explored. Linkages are made to the students' experiences in the surgical team with particular reference to the management of life-threatening illness. Participatory exercises are used to examine loss, drawing on the students' own experiences. The discussion that follows these exercises provides an opportunity to review some of the theoretical descriptions of the process of grieving (Kubler-Ross, 1970; Parkes, 1972; Bowlby, 1979; Worden, 1993; Klass *et al.*, 1996). The principles of assessment and management of pain in advanced disease are included.

Fifth Year

During each of the last three years, two and a half days have been allocated to intensive teaching of palliative care in the fifth year. A two-day workshop is held prior to clinical experience in the inpatient unit at Mary Potter Hospice. This workshop is a mixture of didactic and experiential sessions, aiming for the active involvement by as many of the students as possible. The workshop includes the following elements:

1. The faculty members present the structure and principles of the delivery of palliative care in Wellington and the organisation of the Mary Potter Hospice.
2. The faculty reviews the principles of the assessment and management of *total* pain as understood by palliative care practitioners.
3. Two videos are presented: "Understanding Morphine" (designed primarily for patients and caregivers) and "Mary Potter Hospice—Making the Most of Life" (presenting patients' views about their experiences living with a terminal illness, and staff's views about the Mary Potter Hospice service).
4. Students engage in a "sculpting" exercise (Satir, 1978) that focuses on the dynamics in a family in which a family member is dying. Members of the group take the roles of family members and health professionals. As described by Satir, sculpting participants assume an appropriate posture but

do not speak. At times, however, we extend this exercise to include role-playing. The exercise is followed by a debriefing discussion about the activity.

5. Students discuss theoretical constructs around death, dying and bereavement. Self-disclosure about experiences of loss is encouraged. Participants are asked a set of questions that focus on their own losses. The students' collective experience is discussed in association with case studies provided by the tutor. The aim is to normalise the experience of grief. As students examine the work of theorists, they are asked to look for universal truths and any restrictions or pathologising of the grief response by society. A session on children's grief follows, using an Australian video, "Inside your Feelings," enacted by children, illustrating grief and loss from death and separation. A general discussion follows with emphasis on key points to consider when working with children.
6. Additional experiential work is undertaken on the concepts of loss and separation, and on the task of conveying bad news. Examples drawn from the students' work and experiences are compared with published data (Cushing & Jones, 1995; Heaven & Maguire, 1997).
7. Occupational stress in the care of people who are dying is discussed. The discussion is based on the work of Vachon (1995). In her review of staff stress in hospice/palliative care she identified work stressors, role stressors and stress manifestations. These stressors are discussed and related to the students' own perceptions and experiences.

Often, at the completion of the family sculpting or grief and loss sessions, some students will be quite involved in their feelings of personal loss or life crises. These students are given an opportunity to discuss their feelings with a staff member individually. They are also reminded of the opportunity to meet with the student counselor at the School of Medicine. Each tutorial group differs in how it responds to these sessions. Our experience has shown us that the skills of the tutors in "reading" the group early and the tutors' flexibility in adapting the teaching methods so as to gain the learners' trust and facilitate their involvement, are crucial in having successful experiential learning.

Students return to the hospice in groups of three or four and are encouraged to discuss their hopes and fears about talking with someone at the end of life. Patients are selected and introduced to the students who then interview them. A debriefing session follows in which a senior staff member assists the students in illuminating some of their feelings and in expanding their insights in understanding themselves and in becoming optimally available to others. Concepts involved in self-knowledge can be difficult to grasp and understand. The importance of this aspect of practice in maintaining individual well-being is linked to the earlier session on occupational stress.

Students are also given the opportunity to use this experience as the basis for their case formulation, which is part of their assessment in the Psychological Medicine attachment. They are required to write an assignment in relation to

one of the patients they have seen, discuss the case history, provide a differential diagnosis and describe plans for additional assessment and clinical management.

Later in the year more formal input into the clinical pharmacology module is undertaken in lecture format with particular reference to pain, constipation and general symptom management.

Sixth Year (Trainee Intern)

Since the early 1980s students have been attached to our service for two days during which they experience the day-to-day running of the inpatient unit. Students are encouraged to become involved in multidisciplinary team functions and to work on the ward, interviewing patients and their families. Students can attend the day unit or outpatient sessions or, with one of the staff, they can visit people at home. Again, emphasis is on a holistic approach to management of individuals and families.

Students in all three years are provided with articles and clinical protocols covering relevant areas of practice.

By providing a longitudinal approach to teaching we hope to help the students become more familiar with the principles and practices of palliative care. The activities outlined here often provide an overlap from one year to the next to help the students regain confidence. One of the disadvantages of three relatively short exposures to palliative care is that each one may not be long enough to be deemed important by the students—especially as there is no defined component in their final examinations.

Evaluation

Much of the evaluation previously reported in the literature has tended to emphasise mechanistic and simplistic approaches to palliative care education (Smith, 1996). Discussion has taken place about improving the effectiveness and relevance of assessment and evaluation in palliative care education (MacLeod & James, 1997). One of the aims of our program is to encourage students to be more aware of their role in caring for people, as distinct from curing them.

Fourth year evaluation is on an informal basis by verbal feedback, but assessment of knowledge is made by the addition of questions concerning palliative care in the end-of-year surgical exam.

Fifth and sixth year placements end with a written evaluation of their learning experience and the teaching strategies involved. For the fifth year placement this is undertaken after they have completed the debriefing from the patient interview, although some verbal evaluation is part of the debriefing itself. The written evaluation includes the following questions:

- What have you learned from this placement?
- How has the placement changed you?
- What did you feel comfortable with?
- What was missing from the programme for you?

There is also a space for general comments.

The response rate for the 1998 academic year was 52 responses from 72 students (72%) which is typical for the rate in prior years. The following are some key findings for the students' self-reported learning and attitude changes:

- they found that hospice/palliative care services were clarified;
- they recognised that patients and families must be seen as people first;
- their understanding of the care of people who are dying was broadened and their own comfort levels around death and dying was improved;
- their understandings of the importance of good communication, and their need for developing rapport and listening skills were enhanced;
- they recognised and appreciated how the hospice experience made an impact on them.

Students often identified increased confidence with the patient interview, but a general discomfort with aspects of the tutorial process. Some students expressed discomfort by displaying negative feelings within the tutorial group, especially when personal experiences of death were discussed. This discomfort was also apparent if and when a patient did not appear to want to answer their questions or when a patient asked the student for information.

Despite these reservations, the majority of students asked for more time at the hospice and for more patient contact.

The written evaluation forms for sixth year placements have included a pre- and post-test. These tests measure the students' perceived changes in confidence in practicing palliative care, changes in their ability to cope with dying (their own and the patient's), knowledge of local palliative care services and drugs, and issues for patients and families around loss and grief. A modified Likert five-point scale is used for students' self-evaluation. A general written evaluation is also used to determine student perceptions of their learning. The questions used are:

- Describe three aspects of the placement which were valuable for you.
- Describe what could be improved in this placement to enhance your clinical skills.
- Identify aspects of your own performance that you would like to change as a result of what you have learned.
- List at least two recommendations that you would make to a student coming to this placement.

More than half of the 35 responding students for 1998 identified a significant increase in confidence in providing palliative care. No students reported losing

confidence. Most of the students indicated their ability to cope with death and dying had improved. None reported losing confidence.

All students reported that their knowledge of services improved. Most students indicated that their knowledge of drugs improved and some reported that their knowledge of issues around loss and grief increased.

The students valued the opportunity to be part of a team, to witness medical interaction with someone who is dying and their family, and their own involvement in communication over time with a patient and family. Again, students asked for more time at the hospice.

No formal attempt has yet been made to find out if other faculty members at the Wellington School have identified any changes in the way students approach death and dying in other clinical areas. Evaluation of the assessment skills of the clinicians making referrals to the palliative care service is in progress and a more accessible route for postgraduate work in this area is proposed.

Conclusion

The development of a holistic approach to teaching about living and dying has had a positive response from students in their clinical years. Throughout the time that Mary Potter Hospice has been involved with teaching the students have consistently asked for more time at the hospice and more "hands on" experience. We conclude that palliative care learning can be managed over the span of a medical student's clinical education. With the combination of didactic and experiential methods using a multi-professional team before students attend patient interviews and ward responsibilities, significant impact on their knowledge, confidence in their own skills, and a greater understanding of self has been demonstrated.

The challenge for the future is to build on the work undertaken here and to try to co-ordinate all palliative care teaching in this clinical school (and others) in a more effective way.

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References

- AUSTRALIA and NEW ZEALAND SOCIETY OF PALLIATIVE MEDICINE (1997). *Australasian undergraduate medical palliative care curriculum*. Victoria, Australia: ANZSPM.
- BOWLBY, J. (1979). *The making and breaking of affectional bonds*. Tavistock, London.

- CUSHING, A.M. & JONES, A. (1995). Breaking the bad news. *Medical Education*, 29, 430–435.
- FIELD, M.J. & CASSEL, C. (Eds) (1997). *Approaching death: improving care at the end of life*. Institute of Medicine, Washington, DC: National Academy Press.
- HEAVEN, C. & MAGUIRE, P. (1997). *Assessing patients with cancer*. London: Cancer Research Campaign.
- KLASS, D., SILVERMAN, P. & NICKMAN, L. (Eds) (1996). *Continuing bonds; new understandings of grief*. London: Taylor & Francis.
- KUBLER-ROSS, E. (1970). *On death and dying*. London: Tavistock.
- MACLEOD, R.D. & JAMES, C.R. (1997). Improving the effectiveness of palliative care education. *Palliative Medicine*, 11, 375–380.
- MACLEOD, R.D. & NASH, A. (1992). Taking the lid off—observations of the process of palliative care education for general practitioners. *Postgraduate Education for General Practice*, 3, 28–33.
- MACLEOD, R.D. & NASH, A. (1994). Multidisciplinary education in palliative care. *Journal of Interprofessional Care*, 8, 283–288.
- PARKES, C.M. (1972). *Bereavement. Studies of grief in adult life*. Harmondsworth: Penguin.
- SMITH, A. (1996). Continuing education and short courses. *Palliative Medicine*, 10, 105–111.
- SATIR, V. (1978). The simulated family. In: V. SATIR (Ed.), *Conjoint family therapy*. London: Souvenir Press.
- VACHON, M.L.S. (1995). Staff stress in hospice/palliative care: a review. *Palliative Medicine*, 9, 91–122.
- WORDEN, W. (1993). *Grief counseling and grief therapy*. London: Routledge.

Learning to care: a medical perspective

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Abstract: The development of palliative care as a recognizable specialty has been supported by an acknowledgment of palliative medicine as a discrete discipline within the medical profession. While the knowledge and skills required for training in palliative medicine are well defined, there are elements of the medical care of people at the end of life that are more difficult to outline. Nursing practitioners and academics in particular have made important contributions in defining caring as an entity, and published work in the field of nursing, bio-ethics and philosophy has encouraged an understanding of what caring is and how it is practised. However, it has rarely been addressed specifically in the medical literature. Undergraduate and postgraduate curricula outline some of the attitudes required to practise palliative medicine but the way in which doctors learn to care and indeed should care has not been clearly detailed. This paper reviews some of the literature pertinent to this aspect of palliative care, with particular reference to some of the elements that may influence how and why doctors learn to care in the way that they do in their practice of medicine.

Key words: education, medical; empathy; learning; palliative care; socialization, medical (nonMeSH)

Resumé: La reconnaissance des soins palliatifs comme spécialité à part entière a été obtenue par la consécration de la médecine palliative comme une discipline mineure au sein de la profession médicale. Pratiquer les soins palliatifs requiert des connaissances et des aptitudes bien définies alors qu'il est plus difficile de préciser quels sont les éléments de la prise en charge médicale des patients en fin de vie. Les praticiens en soins infirmiers et les universitaires en particulier ont largement contribué à définir les soins palliatifs comme une entité à part entière et ont publié des travaux tant dans le domaine des soins infirmiers que dans celui de la bioéthique et de la philosophie permettant de comprendre ce qu'est le soin et comment il se pratique. Cependant, ceci a rarement été abordé de façon spécifique dans la littérature médicale. Dans les programmes pré et post-doctoraux quelques attitudes requises en situation palliative sont soulignées mais la façon dont les médecins apprennent à soigner et devraient en fait soigner n'est pas clairement explicitée. Cet article fait une revue de la littérature sur ce sujet dans le domaine des soins palliatifs avec une attention particulière à quelques uns des facteurs qui déterminent pourquoi et comment les médecins apprennent à soigner de façon réellement pratique.

Mots-clés: enseignement médical; empathie; apprentissage; soins palliatifs; participation à l'activité médicale (non référencé)

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Introduction

The development of palliative medicine as a discrete and recognized medical specialty has led to the introduction of curricula at both undergraduate and postgraduate levels of learning. Clearly, much of what is taught and what is learned is of a technical and knowledge-based nature. This is fundamental in any medical practice and particularly relevant in a specialty where so many patients have such a wide range of medical problems. It would be seductive to imagine that the essence of palliative medicine lies within these technical and knowledge-based areas, but it is essential that those responsible for teaching and learning in this area maintain a focus on those aspects of the discipline that are less easily quantified and identified. In any domain of professional practice it is important to identify the true nature of that practice. Professional practice involves not only professional content but also professional process and it is in the untangling of these two elements that we can discern something of the difficulty facing those responsible for the training of palliative physicians for the future. Palliative care cannot be seen solely in terms of skills and knowledge – it must include those processes that can be identified as metacognitive and reflective as well.¹

This paper reviews some significant influences in the way that doctors might learn to care for people who are dying. By reviewing some of the literature concerning the process known as medical socialization, as well as work on the concepts of caring and empathy, some inferences can be drawn on the nature of learning to care for people at the end of life.

Medical socialization

One of the most simple reasons that medical students go to school is to be changed. This process of change is complex and can be considered to be most heavily influenced by the process of medical socialization.

When sociologists write about medical socialization they refer to the learning of attitudes, norms, self-images, values, beliefs and behaviour patterns that are associated with becoming a doctor.

Sociologists have been impressed by the powerful effect of the medical world in changing or altering attitudes, beliefs and values. There is not always

agreement on the most powerful influences in this process of socialization but one area that has attracted much attention is that outlined by Renee Fox, described as the 'human condition' and 'existential' aspects of medicine:

Health, illness and medical care are integrally connected with some of the most basic and the most transcendent aspects of the human condition ... The experience of illness and the practice of medicine ... summon up critical problems of meaning – fundamental questions about the 'whys' of pain, suffering, accident and angst. ...²

Medical socialization is a long and complicated process, which is highly structured, uniform and contains collective experiences that draw medical people together. Essentially, all medical students pass through a similar basic core curriculum – they share experiences and learn similar topics. Their formative experiences separate them from non-physicians and the public at large. The kinds of shared experiences that set them apart are those connected with life, with birth, with death and with the human condition. A great interest in this process developed in the 1950s and 1960s when a number of landmark studies of medical socialization were published by social scientists. Reference to this work continues and is of particular relevance to medical educators. The concerns of these educators are the importance of developing attitudes and values that promote caring and concern for the individual and society, as well as the difficulty of teaching the psychological, social, cultural and humanistic aspects of health, illness and medicine as effectively as biomedical knowledge and skills.³

Themes that seem to have attracted most attention in this area are the attitude-learning sequences of 'training for uncertainty and limitation', 'training for detached concern' and training in management of medical mistakes and failure. These sequences have been challenged by Atkinson,⁴ who suggests that 'certainty' and 'uncertainty' should be seen as two separate phenomenological issues that may co-exist simultaneously, reflecting different practical and theoretical interests. Disease and ill-health are culturally defined and cannot necessarily be seen in concrete terms – the human being suffering ill-health is not completely 'knowable', therefore elements of the science of medicine remain uncertain. The consequence of this is that the elements of ill-health that can be controlled to

some degree more readily become the focus of constant improvement or learning. As a society we have been encouraged to believe in the most scientific aspects of medicine and this is encouraged in the process of socialization.

'Why do doctors do what they do?'

Socialization has been described as 'the process by which people selectively acquire the values and attitude, the interests, skills and knowledge – in short, the culture – current in the groups to which they are, or seek to become, a member'.⁷ Becker *et al.*,⁸ in their classic study of the socialization of medical students, describe a process of what they call situational adaptation; the students focus on the immediate present and forget about the process of socialization itself. Much of their work is influenced by their understanding of the concept of symbolic interaction first enunciated in the 1930s by John Dewey and others.⁸ This theory assumes that human behaviour can be understood as a process in which the person shapes and controls his conduct by taking into account the expectations of others with whom he interacts. As a result of their experience in school, medical students acquire a point of view and terminology of a technical kind, which allows them to think about patients and disease in a way quite different from that of the layman:

They look upon death and disabling disease, not with the horror and sense of tragedy the layman finds appropriate, but as problems of medical responsibility.⁸

The process of change

In his study of the socialization of first year medical students, Frederick Hafferty⁹ talks of the students' belief that their training is a rite of passage, interwoven with emotional and physical trials. They move into a different culture and structure of rules that are particularly pertinent when considering the care of dying people. How do physicians learn to deal with something that is at odds with what medicine is trying to do? In their training, medical students first confront conflicts between emotions and their dual status as a lay and medical person. Hafferty suggests that the students' preoccupation with the academic rigours of medical training directs their attention away from the inculcation of values and attitudes concerning what it means to be a physician. He feels that they are engulfed by their

role as basic science students initially and thus distanced from their role as physicians-in-training and that they believe their survival depends on focusing on the present and the accumulation of scientific facts. There is, however, another tension which comes early on in the students' career. Early exposures to death and dying act as rites of passage or separation, distancing them from their previous lay identities and allowing them to move towards a more 'medical' persona.

Hafferty also identifies the tension between medicine's dominant values of detachment and distance and lay values of concern and affectivity.

This conflict was identified in a slightly different form, decades earlier, by Francis Peabody in his now classic paper.¹⁰ The practice of medicine in its broadest sense includes the whole relationship of the patient with his physician. Even at that time, students were taught a great deal about the mechanism of disease but very little about the practice of medicine. The training had become too scientific and the students did not know how to take care of patients. There is little evidence that much has changed. Treatment of disease may be entirely impersonal, but the care of a patient must be completely personal. Pressure of work leads to doctors primarily treating disease; consequently, this is not conducive to establishing a personal relationship. Peabody writes of a:

... great group of patients in which it is not the disease but the man or woman who needs to be treated ... The good physician knows his patients through and through and his knowledge is bought dearly. Time, sympathy and understanding are needed. The reward is to be found in that personal bond which forms the greatest satisfaction of the practice of medicine.

The secret of the care of the patient is in caring for the patient.¹⁰

Is it not important then for us in medicine to encourage students to learn about empathy, sensitivity and compassion? By the time they start practising medicine most doctors have undergone two decades of learning. As medical students these doctors started with a dead body and were quickly taught everything that was similar in each human being, and that process continues. As they progress, their compassion and understanding of what makes people different declines. Students increase their ability to act independently but decrease in benevolence during the beginning years of medical train-

ing. Shifts in interpersonal values begin before the first day of medical school – socialization begins prior to the start of formal training.¹¹

Training for uncertainty

Students encounter a vast field of knowledge and soon discover that they cannot master it all. They are socialized into uncertainty. 'Uncertainty and death [are] the only certainties.'³

These uncertainties are divided into three broad areas. First, there is an uncertainty that accompanies their incomplete knowledge and the ever-increasing burden of information that modern medicine accumulates. Secondly, they realize the uncertainty that flows from the gaps, deficiencies and ambiguities that accompany that information. The third uncertainty relates to coming to terms with the dilemma of whether these gaps are there because of personal ignorance or rather the imperfect or deficient aspects of 'scientific' knowledge that medicine espouses. As learners they often don't know what they don't know, but they also don't know what medicine doesn't know. So often they see their teachers and role models behave in a way that suggests to them that those people *do* know and this compounds their uncertainty.

First year students are able to elicit more of the purpose for which an appointment was sought by a patient than the students in the third and fourth year who are more influenced by their clinical expectations.¹² They learn detached concern for people and therefore learn to detach emotionally. This process may be a developing one as, whereas until a few decades ago physicians could only care for their patients, now the chance to cure so many makes science and technology irresistible.¹³ The rewards in medicine are usually greater for a 5-min technical procedure than for an hour of emotionally draining bedside care. It is relatively easy to publish an article describing a new enzyme or technique, but more difficult to publish an article on kindness or empathy.¹⁴

Caring

Most of the relevant writing on caring for ill and dying people has been provided by the nursing profession; remarkably little has come from the medical profession. Palliative care must include respect

for autonomy, justice, nonmaleficence and beneficence. The context of death exerts a powerful influence over what is said, received and interpreted and professionals must relinquish control, share decision making and treat patients and families as partners. They should act with humanity and they have an obligation to provide caring concern.¹⁶

Caring can be thought of as a behaviour or as a motivation. As a behaviour, it is often thought to mean 'looking after people and seeing to their needs'. As a motivation it can refer to being fond of someone, feeling sympathy or empathy for that person, being concerned for their well-being or having a professional commitment to them. It could be argued that the best caring professionals show both of these aspects of care. If we care about anything or if we care for someone it is because deep caring is part of the very nature of our being.¹⁷

Caring and humanity

A humanistic model of caring is characterized by that caring being a moral obligation or duty. An individual has an obligation to promote the good of someone with whom he or she has a special relationship.¹⁸ This is the type of caring that physicians and nurses are called on and expected to provide. It is a caring created by the obligation to act in a beneficent manner:

Caring is the expression of our humanity and it is essential to our development and fulfilment as human beings.¹⁹

Leininger²⁰ supports this view in writing that caring is the essence of humanity, and that it is essential for human growth and survival. She contends that care is one of the most powerful and allusive aspects of our health and identity and must be the central focus of the helping and healing professions. This approach is further supported by the work of Roach,²¹ who asserts that care forms the basis of human existence. She writes that 'when we do not care we lose our being and care is the way back to being'.²²

Caring then is proposed as the human mode of being. Human care has been a focus of special interest to philosophers, theologians, poets and artists for centuries. Examination of literature from social scientists and philosophers establishes caring in varying perspectives. Caring interactions are interpreted as helping the recipient to overcome sepa-

ration from others.²³ Caring helps people to grow.²⁴ One must know the person to understand the other's needs and transform that knowledge into action. Gabriel Marcel²⁵ interprets caring as more than physical presence. Existential presence involves availability, openness and a giving to others so that a sense of value and respect are communicated. The differing attitudes of caring have been enumerated as the 'five Cs'.²¹ Caring is expressed in compassionate and competent acts in relationships qualified by confidence through an informed sensitive conscience and through commitment and fidelity.

It is suggested that caring conveys moral meaning because it is attached to a (religious) tradition, which gives it meaning and forms its basis.²⁶ Indeed, much of the founding work in palliative care evolved from a religious motivation, as many of the pioneers in this work were strongly motivated by Christian teachings. This religious inspiration remains today, with churches and religious orders maintaining significant influence in the provision of the care of people who are dying.

Caring as a behaviour

Caring has subsequently been characterized or described as a phenomenon, a life force, a process, a behaviour, an ideal, a principle and a virtue so it is not surprising that the phenomenon of caring has proved rather difficult to encapsulate in any one deed or deeds. Fry²⁷ chose to characterize caring in one of three models. The cultural model was developed from anthropological and sociological studies of caring behaviours in various cultures.

The anthropological record of the long survival of humans makes us pause to consider the role of care in the evolution of humankind. Different ecologic, cultural, social and political contexts have influenced human health care and the survival of the human race.²⁸

In examining a bioethical basis for caring, van Hooft¹⁷ revisits the work of Heidegger and Levinas to argue that caring is an ontological structure of human existence, which takes two forms: caring about oneself and caring about others. Heidegger²⁹ asserts that a human being is constantly oriented towards the future and acting from out of his past so that caring is rooted in our previous experience of that 'way of being'. Van Hooft also extends his argument to include the Aristotelian levels of

human living and suggests that virtue-based ethical theory may be the only way of holistically embracing all dimensions of caring. The key concept of virtue theory is that something deep within a person comes to be expressed as moral action.

The feminist model of caring

A number of authors, most memorably Noddings,³⁰ have chosen to describe caring within a feminist perspective of moral development and cultural practice. They suggest that human caring is a phenomenon and an attitude that expresses our earliest memories of being cared for and they further suggest that it can be learned and nurtured in the educational process. This stance has been challenged by other feminist writers. Dalley³¹ believes that the idea that women are naturally caring by virtue of their psychological make-up has resulted in the expectation that women are to perform the caring tasks in society. This view is supported³² by the belief that such things as decisive behaviour, rational thinking and competitiveness are seen as masculine attributes while irrationality, docility and sacrificing personal needs are feminine attributes.

Developing models of care

A later development of Fry's work³⁴ moved away from the idea of three separate models for caring and concentrated more on care as being either inherently obligation oriented or inherently covenant oriented. The obligation model of care highlights aspects of compassion, doing good for others and medical competence, which are all directed towards the good of an individual. One cares in order to produce some good or to create some benefit for another individual. The covenant model is based on the maintenance of fidelity in the relationship with another being. Competence is an additional dimension that should be included in both of these elements of caring.

Jean Watson³⁵ has written that 'human caring involves values, a will, and a commitment to care, knowledge, caring actions and consequences'. It has been suggested³⁶ that the necessary conditions for caring include:

- an awareness and knowledge about one's need for care;
- an intention to act and actions based on knowledge;

- a positive change as a result of caring judged solely on the basis of welfare of others.

The most abstract characteristics of a caring person are that he or she is somehow responsive to a person as a unique individual, perceives the other's feeling and sets apart one person from another and from the ordinary.³⁷

Watson also writes that care can begin when an individual enters into the life-world or phenomenal field of another person and is able to detect the other person's 'condition of being'. People who care should respond to that condition of being in such a way that the recipient is able to let go of subjective feelings and thoughts he or she had been longing to release. She defines this as transpersonal caring and it depends upon a number of elements. First, there is a moral commitment to protect and encourage human dignity so that individuals can understand their own sense of meaning. Secondly, there is a necessity to affirm the value and significance of the other and thirdly, an awareness and attempt to understand the feelings of another (by an attentive presence in the relationship). Finally, both parties need to be aware of the relationship and acknowledge that previous life experience exerts a powerful influence on that relationship. One of the challenges for medical educators is to try to identify which of these models of care is most appropriate for doctors in training.

In his book *The illness narratives*, Arthur Kleinman³⁸ outlines his understanding of how the interpretation of illness meanings or narratives can contribute to more effective care. He sets out a practical clinical method that practitioners can apply to provide more effective and humane care to people who are sick. He contends that ultimately what the practitioner does best is to organize care around the phenomenological appreciation of the illness experience and its psychological and social consequences for the patient.

Kleinman further expands on the development of his rationale for a practical clinical methodology in the care of the chronically ill. The essence of that methodology is captured in the words 'empathic listening', 'translation' and 'interpretation'.

Empathy

Empathy is an elusive concept in medicine. Freud described it as 'the mechanism by means of which

we are enabled to take up any attitude at all towards another mental life'.³⁹

Empathy is what we see when a picture moves us or for some it is what we hear and feel when music moves us. Empathy is much more than just knowing what we see or feel; it is the image and the emotion generated by the picture or the music. Empathy helps us to know who we are and what we feel. Spiro⁴⁰ claims that conversation helps us to develop empathy, 'for it is here that we learn of shared experiences and feelings'.⁴¹ The idea of empathy that is truly crucial for clinical practice is that of genuine attention to the individual's concerns and the acceptance of those concerns. Empathy can be thought of as a mode of caring. It is an openness to, and respect for, the individuality of another human being.

Francis Peabody¹⁰ emphasized the importance of getting to know the patient as a major part of the art of medicine. By writing that the art of medicine and the science of medicine were not antagonistic but supplementary to one another, he was essentially saying that empathy is a prerequisite for the effective care of any patient. It was perhaps particularly poignant that Peabody was terminally ill when he wrote the article. Empathy, therefore is seen as essential for the effective care of all patients but it has been acknowledged by some physicians as problematic.⁴² Some physicians see their emotions as projections of their own needs or wishes onto patients that interfere with making objective diagnoses and providing reliable care. They develop a mode of functioning with 'detached concern' that makes it easier to heal or help patients.

Sir William Osler⁴³ wrote that 'it is a safe rule ... to have no teaching without a patient for text and the best teaching is taught by the patient himself'. This was written in 1904 in an attempt to encourage students to learn at the bedside rather than through books alone. This assertion encourages students to pay heed to the patients' stories and the themes that flow from them.

Empathy in literature

There are numerous examples of empathy and the care of people who are dying in literature and poetry. Each clinician collects his or her own stories and all will know of published work that illustrates both empathy and care at the end of life. The few identified here give an indication of the breadth of mate-

rial available in understanding the significance of empathy in caring.

- Biblical writings such as the account of the Good Samaritan (Luke 10: 30–37), the care of the stranger (Matthew 25: 31–40) and the compassion and empathy with the sick (Mark 1: 40–45).
- L Tolstoy (1886–1960) *The death of Ivan Ilyich*.
- DH Lawrence (1885–1930) *All Souls' Day*.
- N Elias (1985) *The loneliness of the dying*. Oxford: Blackwells.
- J Alexander Brice (1987) Empathy lost. *Harvard Medical Alumni Bulletin* 60(4): 28–32.
- A Kleinman (1988) *The illness narratives*. New York: Basic Books.
- L Eisenberg (1981) The physician as interpreter: ascribing meaning to the illness experience. *Comprehensive Psychiatry* 22: 239–48.

Conclusion

Echoing Sir William Osler, Janet Grant recently wrote⁴⁴ that medical education is about learning to be a doctor by being a doctor. In an editorial in *Medical Education*, John Bligh⁴⁵ suggests that learning through caring means using clinical contact as the prime element of the educational process, but it is surely more than that. Modern medicine is founded on extensive and arduous scientific education aided by increasingly sophisticated diagnostic tools. However, we ultimately have to understand how a disease affects each individual and to move on from the difficulty of making a diagnosis to the more challenging aspect of medical care.

The concept of caring is elusive in medical practice. The way in which doctors learn to care, or at least begin to learn, is heavily influenced by the process of socialization through which all medical students have to go. By definition, this is a transforming process, but there is little evidence to suggest that there is much emphasis given to aspects of caring as students travel through that process. By acknowledging work undertaken, primarily in the fields of nursing and bioethics, those responsible for helping doctors to learn can go some way towards understanding what is meant by caring in a medical context. By encouraging an empathetic approach to all aspects of medical practice we can help students to learn who and what they are and how they might be better equipped to support and care for people at the end

of life. Listening to people's stories, reading the work of clinicians and writers who are able to accurately portray what it may be like in the life-world of someone who is dying, and allowing oneself to identify with people at the end of life are all routes towards an understanding of the notion of care in this context.

If the practice of medicine is to escape the bureaucratic and technological stance of the end of the twentieth century, emphasis must be given to those elements that contribute to an ethic of care for the profession as a whole. Palliative care, and more specifically palliative medicine, must continue to embrace a broad concept of health and illness in order that physicians of the future know what it means to truly care.

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References

- 1 James CR, MacLeod RD. Teaching and learning in palliative care: future considerations. In: MacLeod RD, James CR eds. *Teaching palliative care: issues and implications*. Penzance: Patten Press, 1994.
- 2 Fox RC. *The human condition of health professionals*, Distinguished Lecturer Series. Durham, NH: School of Health Studies, University of New Hampshire, 1980.
- 3 Fox RC. *The sociology of medicine – a participant observer's view*. Englewood Cliffs, NJ: Prentice Hall, 1989: 73.
- 4 Atkinson P. Training for certainty. *Soc Sci Med* 1984; 19: 949–56.
- 5 Bosk CL. The doctors. *Wilson Quarterly* 1980; Spring: 81.
- 6 Sacks O. *The man who mistook his wife for a hat, and other clinical tales*. New York: Summit Books, 1985: xiii–xiv.
- 7 Merton RK, Reader GG, Kendall PL eds. *The student-physician: introductory studies in the sociology of medical education*. Cambridge, MA: Harvard University Press, 1957.
- 8 Becker HS, Geer B, Hughes EC, Strauss AL. *Boys in white – student culture in medical school*. New Brunswick, CT: Transaction Publishers, 1961.
- 9 Hafferty FW. *Into the valley: death and the socialization of medical students*. New Haven, CT: Yale University Press, 1991: 187.

- 10 Peabody FW. The care of the patient. *J Am Med Assoc* 1927; **88**: 877–82; 1984; **252**: 813–18.
- 11 Harvill LM. Anticipatory socialisation of medical students. *J Med Educ* 1981; **56**: 431–33.
- 12 Reiser SJ. Science, pedagogy and the transformation of empathy in medicine. In: Spiro H, McCrea Curnen MG, Peschel E, St James D eds. *Empathy and the practice of medicine*. New Haven, CT: Yale University Press, 1993: 128.
- 13 Spiro HM. What is empathy and can it be taught? In: Spiro H, McCrea Curnen MG, Peschel E, St James D eds. *Empathy and the practice of medicine*. New Haven, CT: Yale University Press, 1993: 7.
- 14 Glick SM. The empathetic physician: nature and nurture. In: Spiro H, McCrea Curnen MG, Peschel E, St James D eds. *Empathy and the practice of medicine*. New Haven, CT: Yale University Press, 1993: 87.
- 15 Miyaji NT. The power of compassion: truth-telling among American doctors in the care of dying patients. *Soc Sci Med* 1993; **36**: 249–64.
- 16 Latimer E. Caring for seriously ill and dying patients: the philosophy and ethics. *Canad Med Assoc J* 1991; **144**: 859–64.
- 17 van Hooft S. Bioethics and caring. *J Med Ethics* 1996; **22**: 83–89.
- 18 Pellegrino ED. The caring ethic: the relation of physician to patient. In: Bishop AH, Scudder JR eds. *Caring, curing, coping: nurse physician, patient relationships*. Birmingham, AL: University of Alabama Press, 1985.
- 19 May R. *Love and will*. New York: WW Norton, 1969.
- 20 Leininger MM. Leininger's theory of nursing: cultural care diversity and universality. *Nurs Sci Quarterly* 1988; **1**: 152–60.
- 21 Roach MS. *Caring: the human mode of being, implications for nursing*, Perspectives in Caring, Monograph 1. Toronto: University of Toronto, Faculty of Nursing, 1984.
- 22 Roach MS. *The human art of caring: a blueprint for the health professions*. Ottawa: Canadian Hospitals Association, 1987.
- 23 Fromm E. *The art of loving*. New York: Harper Row, 1956.
- 24 Mayeroff M. *On caring*. New York: Harper Row, 1971.
- 25 Marcel G. In: Gibson R ed. and trans. *The philosophy of existence*. Philadelphia, PA: University of Pennsylvania Press, 1981.
- 26 Bradshaw A. Yes! There is an ethic of care: an answer to Peter Allmark. *J Med Ethics* 1996; **22**: 8–12.
- 27 Fry ST. The philosophy foundations of caring. In: Leininger MM ed. *Ethical and moral dimensions of care*. Detroit, IL: Wayne State University Press, 1990.
- 28 Leininger MM. *Care: the essence of nursing and health*. Detroit, IL: Wayne State University Press, 1984.
- 29 Heidegger M. In: Macquarie J, Robinson E eds. *Being and time*. Oxford: Blackwells, 1973: 192.
- 30 Noddings M. *Caring: a feminine approach to ethics and moral education*. Berkeley, CA: University of California Press, 1984.
- 31 Dalley G. *Ideologies of caring*. Basingstoke: Macmillan, 1988.
- 32 Salvage J. *The politics of nursing*. London: Heinemann, 1985.
- 33 Clack GB, Head JO. Gender differences in medical graduates' assessment of their personal attributes. *Med Educ* 1999; **33**: 101–105.
- 34 Fry ST. A theory of caring: pitfalls and promises. In: Gaunt DA, Leininger MM eds. *Caring: the compassionate healer*. New York: National League for Nursing Press, 1991.
- 35 Watson J. Human care in nursing. In: Watson J ed. *Nursing: human science and human care. A theory of nursing*. New York: National League for Nursing Press, 1988: 29.
- 36 Gaut D. Development of a theoretically adequate description of nursing. *West J Nurs Res* 1983; **54**: 315.
- 37 Watson J. Nature of human care and caring values in nursing. In: Watson J ed. *Nursing: human science and human care. A theory of nursing*. New York: National League for Nursing Press, 1988: 31.
- 38 Kleinman A. *The illness narratives*. New York: Basic Books, 1988.
- 39 Freud S. Group psychology and the analysis of the ego. In: Strachey J ed. and trans. *The standard edition of the complete psychological works of Sigmund Freud*, vol. 18. London: Hogarth Press, 1955.
- 40 Spiro HM. What is empathy and can it be taught? *Ann Intern Med* 1992; **116**: 843–46.
- 41 Hogenson GB. Depth psychology, death and the hermeneutic of empathy. *J Med Philos* 1981; **29**: 619–23.
- 42 Halpern J. Using resonance emotions. In: Spiro H, McCrea Curnen MG, Peschel E, St James D eds. *Empathy and the practice of medicine*. New Haven, CT: Yale University Press, 1992: 163.
- 43 Osler W. On the need of a radical reform in our methods of teaching medical students. *Med News* 1904; **82**: 49–53.
- 44 Grant J. Training the trainers. *Lancet* 1998; **322**: 19.
- 45 Bligh J. Learning by example. *Med Educ* 1999; **33**: 234–35.



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On reflection: doctors learning to care for people who are dying

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Abstract

Humane care is an essential component of the doctor's role at the end of life. Over the last 20 years, there has been a steady global increase in the extent and variety of medical teaching about the care of people who are dying. In some countries, palliative medicine is now recognised as a discrete medical specialty. Rightly, much emphasis has been placed on symptom management, communication skills and ethical issues. But rarely does the concept of care, or how doctors learn to care, emerge in the medical literature. The concept of "care" is usually defined as a professional behaviour: attending to a patient's needs. Yet, the concept of care also requires a professional commitment on a more holistic level. To care is to be receptive to and responsible for others. This is care motivated by true empathy: a concern for the patient's well-being that comes from a sensitive identification with the patient's situation. This paper reports some of the findings from an interpretive phenomenological study involving 10 doctors and their experiences of learning to care for people who were dying. The doctors came from differing medical disciplines and had varying levels of experience. During the interviews the doctors retrospectively identified "turning points" at which they first perceived some notion of what it means to care for someone who is dying. The doctors often used poignant language when recollecting the strong feelings associated with these critical incidents. They felt that their training had been inadequate in preparing them for such care. The article asks whether their medical education had adequately prepared these doctors for this key element of their work. It recommends ways in which practitioners may be better prepared to care for people who are dying. © 2001 Elsevier Science Ltd. All rights reserved.

Keywords: Palliative care; Hospice; Empathy; Medical education; Medical socialization; New Zealand

"I would urge upon you...to care more for the individual patient than for the special features of the disease....Dealing as we do with poor suffering humanity, we see the man unmasked, exposed to all the frailties and weaknesses, and you have to keep your heart soft and tender lest you have too great a contempt for your fellow creatures. The best way is to keep a looking glass in your own heart, and the more carefully you scan your own frailties the more tender you are for those of your fellow creatures." Sir William Osler (Cushing, 1926)

Introduction

While it constitutes a significant dimension of palliative medicine, the concept of care remains elusive in medical practice. What exactly does care mean in a medical context?

As a behaviour care is often thought to mean looking after people and seeing to their physical needs. As a motivation it can refer to being fond of someone, feeling sympathy or empathy for him or her, being concerned for their well-being. It could be argued that the best caring professionals show both of these aspects of care. In the clinical setting, the caring physician exhibits two primary attributes: receptivity and responsibility (Branch, 2000).

Studies in Britain have suggested that the years 1969–1987 witnessed a move towards more open dialogue

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between doctors (particularly hospital doctors) and dying patients and their families. This move has been particularly marked in the case of people with cancer, subjects of the greatest focus of the hospice movement (Seale, 1991).

Field (1999) has discussed the positive responses of general practitioners (GP) towards caring for dying people, reporting that they find this aspect of their work important, rewarding and satisfying. However, other studies have identified deficiencies in doctors' abilities to provide the sort of care that patients would like. Seale and Cartwright (1994) found that GPs needed more time to give to dying patients. Moreover, about a third of the GPs who responded had difficulty coping with their own emotional responses.

While studies have shown that GPs wanted more training in palliative and terminal care (Jeffrey, 1994; MacLeod & Nash, 1991), major reviews of activities in the area of palliative care education have failed to identify the concept of care as a central theme within medical training (Billings, 1993; MacLeod, 1994). Field (1995) found that 27 of the 28 medical schools in the UK had some formal teaching in death, dying and bereavement. However, the main focus of that teaching was physical therapy, teamwork and ethical issues in terminal/palliative care; there was no indication that there had been any increased recognition of the concept of care as a distinct entity that should be included in teaching. In the United States, data from the 1997–98 AAMC Annual Medical School Questionnaire revealed only four schools (out of 125) included the topic of death and dying as a separate required course. None had a separate course covering palliative care. The majority of schools did report some elements of end-of-life care in the required courses (Barzansky, Veloski, Miller, & Jonas, 1999). Here too, the focus is on symptom management, ethical issues and communication. Emanuel (1997) has suggested that we need systematic training from medical school through to continuing education.

Care

"Humane care for those approaching death is a social obligation as well as a personal offering from those directly involved". So begins the report of the US Institute of Medicine *Approaching Death: Improving Care at the End of Life* (Field & Cassel, 1997). Care, both in terms of attending to a patient's physical needs and their psychological well-being, may have social and personal motivations.

Various theories exploring the concept of care have attributed to it a sense of social or moral obligation. A number of authors, most memorably Noddings (1984) have defined care from a feminist perspective. They suggest that human caring is a phenomenon and an

attitude that can be learned and nurtured in the educational process. An alternative, humanistic model of caring is characterized by the sense that caring is a moral obligation, a mode of being that calls for a philosophy of moral commitment to protecting human dignity. This is the type of caring that physicians and nurses are called on and expected to provide; it is a caring created by the obligation to provide good.

Caring may also be approached from a bioethical basis. van Hooft (1996) revisits the work of Heidegger and Levinas to argue that caring is an ontological structure of human existence that takes two forms: caring about oneself and caring about others. He extends his argument to include the Aristotelian levels of human living and suggests that virtue-based ethical theory may be the only way of holistically embracing all dimensions of caring. Not only is caring a moral orientation but it incorporates the attributes of honesty, respect and trustworthiness into all aspects of moral behaviour (Branch, 2000).

Yet aside from the notion of moral obligation, the concept of care also concerns what the United States Institute of Medicine calls a "personal offering" (Field & Cassel, 1997). The caring person listens, responds and relates to the patient as a unique individual, attempting to understand the other's needs and feelings (Kutner, Steiner, Corbett, Jahnigen, & Barton, 1999; Watson, 1988). Care can begin when one individual enters into the lifeworld of another person and attempts to understand what it is like to be that person. This process, known as empathy, may be an important route for doctors who intentionally or otherwise develop caring skills by empathising with their patients.

Empathy

Empathy is the ability to put oneself imaginatively in the place of another; it helps us to know who we are and what we feel. The aspect of empathy crucial to clinical practice concerns paying genuine attention to and accepting the individual's concerns (Watson, 1988). By focussing on the impact of the disease and its treatment on a person's ability to lead a meaningful life, we gain an understanding of what it might be like to be in that situation. Empathy is a concept relevant to the care of people who are dying because more than anything they are people in need.

In a landmark paper, Francis Peabody provided an eloquent description of the way that care blends medical science with a sympathetic understanding of patients' lives: "the secret of the care of the patient is in caring for the patient" (Peabody, [1927] 1984). For Peabody, getting to know the patient was a major portion of the art of medicine; empathy is a prerequisite for the effective care of any person. (It is particularly poignant

that Peabody was terminally ill when he wrote the article.)

Socialization

The ability of doctors to care is significantly influenced by the socialization process of doctors in training. Socialization has been described as “the process by which people selectively acquire the values and attitude, the interests, skills and knowledge — in short, the culture — current in the groups to which they are, or seek to become, a member” (Merton, Reader, & Kendall, 1957). It is not within the remit of this paper to review the great body of work on medical socialization but a few relevant articles will be identified.

In their classic study of the socialization of medical students Becker, Geer, Hughes, and Strauss (1961) describe a process of students’ situational adaptation to the expectations of supervisors with whom he or she interacts. As a result of their experience in school medical students acquire a technical point of view and terminology that allows them to think about patients and disease in a way quite different from the lay person. They look upon death and disabling disease, not with the horror and sense of tragedy the layman finds appropriate, but as problems of medical responsibility (p. 273). This suppression of empathy not only prevents moral development but may even erode existing moral values (Fendtner, Christakis, & Christakis, 1994). This technical attitude, with its emphasis on pathology, pharmacology and therapeutics, which prevents the student from becoming emotionally involved in the tragedy of patients’ diseases, seems to the layman cruel, heartless and cynical. Frederic Hafferty, in his study of the socialization of first year medical students (Hafferty, 1991), writes of the students’ belief that their training is a rite of passage, interwoven with emotional and physical trials. In their training, medical students first confront conflicts between their own emotional responses and their mixed status as both lay and medical person. He suggests that the students’ preoccupation with the academic rigours of medical training shifts their focus from the development of values, attitudes and ways of acting concerning what it means to be a physician towards a focus on the present accumulation of scientific facts. Early exposures to death and dying, most obviously in the dissection room, act as rites of passage or separation, inevitably distancing students from their previous lay identities and allowing them to move towards a more “medical” being.

While acknowledging that there has been a significant increase in palliative care education within medical teaching, such education has tended to focus on symptom management and organizational issues. Few programmes have been effectively evaluated (Billings & Block, 1997). It is still evident that too many patients are

unprepared for death, too many have symptoms left untreated and too many families are left to face this time feeling isolated and alone (Emanuel, 1997). A clear deficiency remains in the development of attitudes, skills and knowledge that clinicians need to care well for people with end stage disease (Field, 1997).

In order to identify some of the elements that constitute care in the medical setting and to explore how doctors recall learning to care, I conducted an interpretive phenomenological study asking how they learn to care for people who are dying.

Methods

Hermeneutic phenomenology

Interpretive or hermeneutic phenomenology views a phenomenon or experience as a way of interpreting the *being* of human beings. It aims to fill in gaps in our understanding of participants or events. The researcher creates a dialogue between himself and the participants to try to identify practical concerns and lived experience through discussion, narrative and imaginatively *being* in the lifeworlds of the participants. The goal of study is to see a phenomenon in its own terms. This requires critical reflection, personal knowledge and an understanding of the social context within which the phenomenon occurs. Since the focus of a phenomenological study is the essence or structure of an experience (phenomenon) the interviewer’s prior beliefs are temporarily put aside lest they interfere with seeing the structure or elements of the phenomenon. “The process involves a blending of what is really present with what is imagined as present from the vantage point of possible meanings; thus a unity of the real and the ideal” (Moustakas, 1994). In this type of research, attempts are made to obtain narrative accounts of actual situations rather than opinions, ideology or even “what one does in general” in order to create a text that is detailed and realistic.

The researcher

Because my professional world revolves around the care of people who are dying and the teaching of students in this area of practice, there was ample opportunity to observe *care* in many settings before developing the questions. My experience was of 10 years in general practice followed by 10 years full-time in palliative care. During the latter time I have developed an increasing interest in palliative care education.

Interviews

In attempting to gain a broad understanding of how doctors learn to care for people who are dying, a cross-

section of practitioners at different stages in their career and with varying experience were interviewed. The process of maximum variety sampling, selecting a heterogeneous sample to observe commonalities in their experiences, was used. Patten (1990) notes that two types of data are obtained using this technique. The first is high-quality case descriptions, useful for documenting uniqueness; second, significant shared patterns of commonalities existing across participants may be identified. Ten doctors (Table 1) were interviewed from fields of medicine where the care of people who are dying is commonplace (general internal medicine, general family practice and palliative medicine). The interviewees had been trained in different parts of the world and had undergraduate training in differing universities. In this way any deficiencies in training that could be attributed to a particular university were minimized. Interviewees were approached over a 3-week period. All those approached agreed to be interviewed. All were aware of my interest in palliative care education. I attempted to reduce variation in interview approaches and technique by undertaking all the interviews myself. Ethical approval for the project was obtained from the Wellington Regional Ethical Committee for these interviews.

Data collection procedures

The interviews took place at the Mary Potter Hospice, Wellington with the exception of one which took place in a doctor's home and another at Wellington Public Hospital. The interviews were taped with a small portable tape recorder. The interviews were undertaken in a semi-structured way (see the appendix).

Initial questions were aimed at gaining an understanding of the situation of each interviewee in terms of how they chose medicine as a career, what influenced them, what their undergraduate education was like and how prepared they felt they were for the care of people

who are dying. Among these initial questions were some specifically asking if their training had prepared them for the care of people who were dying and if so, how. No specific guidance was given concerning my expectation of their understanding of what constitutes care. In this way I hoped to avoid any narrow focus for this concept.

Concerns emerged in the course of questions about their experiences of caring for people at the end of life and attempts to understand how they had become oriented in certain ways ("can you recall any particular events that have influenced the way that you care for people who are dying?" "How did you learn that?" "How has this influenced your practice?").

Data analysis

Immediately after each interview I made field notes that attempted to reflect the experience of the interview. The recordings were transcribed verbatim. These tapes were then listened to whilst reading the transcript. During that process I was able to reflect on the progress of the interview and to elaborate on my field notes. The first review of the transcripts allowed me to place the responses in the context of my own understanding, experience and presuppositions. My initial interpretive analysis was made by listening to the language of the tapes and the descriptive experiences of the care of people who were dying. Further interpretive reflection on the texts revealed themes that ran through the interviews. When data analysis was completed, these themes were organized into groups and recorded for review. The purpose of phenomenological data analysis is to derive a description of the essential features of an experience from naïve descriptions and specific examples of the experience under consideration. The final aspect of this interpretive analysis involves the identification of paradigms: strong instances of particular patterns of meaning. For simplicity and clarity only responses of immediate relevance to this paper are included here.

Table 1

Interviewee	Years in practice	Gender	Specialty
F	0	F	Internal medicine
D	4	F	General practice
G	3	M	Internal medicine
V	4	F	Geriatric medicine
R	16	M	Palliative medicine
J	14	F	Palliative medicine
			/general practice
L	5	F	Internal medicine
A	21	M	Renal medicine
I	40	M	Palliative medicine
O	4	M	Internal medicine

The relevant issues

Two main themes are identified in this paper: the degree to which doctors felt their education had prepared them for this aspect of their work and the "turning points" that were identified when doctors gained a new perspective of the notion of care and how they became involved in the process of learning to care.

On being prepared

Interviewees felt that their formal education had not adequately prepared them for the task of caring for people at the end of life.

Dr F: "I never presumed my training would equip me for what I may encounter...I believe it gave me theoretical and some practical knowledge on which to build...they expect you to adapt and cope with issues and equip you with all the skills necessary". "I think that your undergraduate training is very rarely addressed in a structured formal fashion".

Dr D: "I don't think I have been trained as such — I came out with a whole lot of facts in my head and really didn't know where to start".

Dr G: "Quite a lot of my ability to handle things, I don't attribute to the training that I had in medical school — we definitely had a few lectures on, one or two on palliative care and that general approach, which in three years is pretty bad. The clinical part of medical school is also, I think, very often not a very real kind of medical experience. Medical students don't have a well defined role; I never had a feeling of sort of belonging on a ward."

Dr J: "...because I think that through all my schooling and through medicine as well, what's important to learn is what someone else has told me to learn, if that makes sense? We must have had something in third year in behavioural science — I just have no memory of it".

Despite the evidence that undergraduate and post-graduate teaching about death and dying has increased, the curative model is still predominantly considered the most relevant for medicine. In the jargon of the curative model, patients whose illness cannot be stopped or slowed are termed "untreatable". From a cure-oriented perspective, the care of such patients is considered outside the purview of medicine (Fox, 1998). Medical students learn humanistic skills in their pre-clinical work but this can often be subtly removed from them during their clinical attachments (Cantwell & Ramirez, 1997). No one model is ideal for all patients in all clinical circumstances. The most suitable model is that which reflects an individual patient's needs; this model should be reflected in the way that doctors are taught. In medicine, technical skills and procedures are rewarded rather than emotionally draining encounters at the bedside, thus placing high value on curative interventions as opposed to palliative, caring interventions. These latter interventions often appear to encourage greater intimacy with the patient. However, even in the palliative care literature there is evidence of the danger of intimacy. While intimacy often takes us by surprise and may hold great promise for feeling connected to others it is often accompanied by the fear that we may be overwhelmed by another's agony, suffering, chaos and disintegration (Barnard, 1995).

Turning points

The doctors in this study intimated that perhaps the most powerful learning occurred when they found themselves in an intimate and caring situation. They identified "turning points" that were often easy but painful to recall — half of the respondents wept as they recounted their stories.

Dr R: "I realise now that one of the early influences for me was a man called Roy. I was a GP and visited him daily for weeks. I could still describe the room, the medications, the dog, the care, even his clothes! He and his wife had been married for decades but they also worked with each other daily. He taught me about symptoms and he taught me the importance of making accurate assessments, because I got it wrong sometimes. They taught me of the importance of broadening the medical role to include an acknowledgment that in many ways I was powerless and vulnerable myself. Towards the end of his life there were no truly "medical" things to do...I was their companion; there was no curative or "medical" role in the accepted sense. Despite knowing that he was dying, when it came, I was devastated".

Dr G: "He was there and he was gone...I just felt very sad...he really stands out. I felt very sad because he was a really nice man. A lovely gentle sort of man with nice views and anyhow that day I stayed later after work just to have a chat with him because I just wanted to talk to him about who he was and what he had done...how he was going to spend his last days. I actually haven't thought about him for months but, you know, looking back on that, for him I feel grief. It wasn't so much that I learned something from him, it was that I met him. If I learned anything from him it was that...er...that I miss him".

Dr V: "I always remember very well the first patient that died while he was in my care. He had had a stroke and there wasn't much that could be done medically but I had spent every day with him for at least an hour getting to know him and we had become quite close..it was horrible [when he died].

Dr L: "I remember...patients in hospital. I had a very close rapport with an old lady who had cancer of the pancreas...who didn't want to live and we were talking in an odd way about life...she was a cleaning lady who had worked as a cleaning lady for a long time... a few weeks before she died she was thinking about the poetry she had written and she ended up writing out sheets and sheets of poetry that she had written as a younger woman, as she did, and

she said she had had the best day of her life... I have still got it [the poetry] ...that was really quite distressing when she died. I came to know and understand a bit of her as a person and I cared a lot about her. [Another man]...the thing I remember about him was his fear. He was relatively young and had a family and children in their teens. He was very afraid...um...well I think how I did the job...it was a matter of finding a reason for...finding what was most important to him. It was just waiting for him to tip over the edge...I remember one really quite horrible episode...I don't think there was anything as gruesome as that. When you have that sort of experience, it becomes easier...it becomes that bit closer to you...that bit more real. The sort of emotional experiences you go through with the patient down the road, it's the patient...you are close to the person".

Dr J: "Most of the people I remember so clearly and vividly and with most distress and emotion were the ones that were really difficult...where there has been something that is really difficult and hard about it and often there isn't an answer. The one that comes back most was when I was a GP and I became involved with a patient. Despite her pain she would dress beautifully every day and she would entertain people...I can remember she wore beautiful jewellery and made herself up. One time I went round and she was so ill she was obviously dying...she let her husband and me take her to bed...and she never got up. I came back later in the day and her 13 year old boy was sitting on her bed and crying and that nearly broke me up...it was seeing that boy sitting on the bed and crying and she was crying too and the day before she had been sitting looking like she could have someone over for afternoon tea and there wasn't anything wrong...and I...it was something about that [weeps]...it was something about that and for me I was awestruck that something about me...or me being involved with them in some way had let this boy cry on her bed.. I just don't know what happened...that was very profound and that was what looking after her was all about.

When she died my predominant feelings were of relief – I almost feel as if I gave too much of myself...because at the end of it I was exhausted... I was relieved when [she] died. She needed me more".

"[Often] they value more than the cure...the compassion and that somebody takes the time to listen and to try and get closer, to understand, to give them..I don't know..the compassionate bit of it I think.."

Dr A: "My sister died when I was twenty six...that was a major sort of...you know it...[weeps] the people that dealt with her at that time were incredibly open with me...I'm not afraid to talk about death but there is something missing about my experience with her. There was a young black guy in New York, 21 years old, who had somehow worked his way through the system and was doing well at university. He had renal failure and at that time you really had to push to get dialysed...if he had been white, middle class, all that kind of stuff he would have been dialysed. Because he was poor and black I overcompensated...and he died and I completely broke down. That had a huge impact on me..but part of it was coloured by the fact that my sister had died. That was the one that sticks out like a beacon".

Many of these "turning point" encounters evoked strong feelings. The doctors often used poignant language to describe these critical incidents.

Dr L: "I don't think there was anything so gruesome. I drove home and I saw this chap's face in front of me all the time...I was really stunned, absolutely stunned...I just burst into tears. It was really shocking and I don't know how to handle it, it was so evil, so gruesome what happened."

Dr D: "I was distraught when he died". "I was really angry about his death". "Unless you have been through that experience you don't really know how bad it is, so I guess that's learning".

Dr G: "I cried and cried". "I still find myself absolutely terrified by the thought of me dying. I am afraid of death, my own death".

Dr J: "I don't know what happened...that was very profound...that was what looking after her was all about". "Even if I don't consciously take that to the next person, I must do... because I am different".

These doctors remembered incidents that may have happened 20 years ago and yet they could describe events in detail as if they occurred yesterday. The doctors seemed to lower their defensive barriers, and open themselves up to a personal vulnerability that remained alive, despite the passage of years. They had become intimately involved and in many situations had been taken aback by that intimacy. It appears as if, in David Barnard's words, reflecting Martin Buber's thinking "the ordinary, goal-oriented transactions of everyday life — the world of 'I and it' — were transformed into a moment of genuine mutuality and relationship — the world of 'I and thou' "(Barnard,

1995). Perhaps the surprise of intimacy has more effect than we realise.

Doctors may be trained to hide behind technical procedures and develop particular ways of dealing with situations so that we can, if necessary, avoid such intimate encounters (de Hennezel, 1998). The training of doctors is designed to help them essentially to feel in control of situations through therapeutic manoeuvres to alleviate symptoms or disease. Generations of doctors have been told “don’t get involved: keep your distance” yet people who are dying are vulnerable, helpless and often powerless, and the doctors involved with those people may not be able to control the very things they have been encouraged to believe they can control. This, in turn, may engender feelings of helplessness and vulnerability in the doctor. de Hennezel writes that ‘teaching relationships or communication techniques to caregivers will not help them to live with this tension; this will come only when they accept their vulnerability and are able to express and share it without fear of being judged’ (de Hennezel, 1998). The challenge for educators is how to harness that learning to effect change for the future.

Discussion

The implications of this research are that traditional, formal education did not prepare these doctors for the task of caring for someone at the end of life but that deep emotional experiences with people who were dying did. The doctors in this study testified most powerfully that they learned about the care of dying people, in an emotional and intimate way, from those dying people.

This study was limited by the group of volunteers who agreed to take part in this review. It could be argued that by their very willingness to participate they already demonstrated an interest in this aspect of their practice. In this type of research the researcher can never escape his own world or background; interpretation of the others’ world by virtue of that background is almost inevitable. Phenomenological investigations seek to uncover experience without foregrounding conceptual thought, yet it must also be acknowledged that there is no such thing as an interpretation-free “true” account of how things are. There is no technical procedure for validating that an account corresponds to the “truth”. Coherence, consistency and plausibility are sought when interpreting results (Benner, 1994). The paradigm cases identified by participants were assumed to be of significance to the participants but they may not be representative in all aspects.

Whether or not phenomenological research is credible is said to depend on the reflective process awakening an inner moral impulse. In some ways this can be considered as whether or not it “feels right”. The

research becomes credible through a validating circle of inquiry, what Buytendijk refers to as the “phenomenological nod”, where the description and interpretation of experience are something we can nod to and recognise as experiences that we had or could have had (van Manen, 1990). In this research the “nod” occurred early on in the process and remained credible throughout.

Improving learning

The most effective learning should be conceived in terms of a continuous process which is grounded in experience. According to Kolb (1984) the learning process involves adapting one’s environment by accommodating ideas, assimilating experience, reflecting and acting. This is described in cyclical terms:

- (a) concrete observation;
- (b) reflective observation;
- (c) abstract conceptualisation;
- (d) active experimentation.

This type of learning is best facilitated by providing a guide or mentor who ensures that the learning process incorporates an explanation of how the learning activities relate to theoretical frameworks at each stage of the cycle. Particular learning activities also depend on the orientation of the workplace as a learning environment and the personal approach of the individual to learning.

A deep approach to learning, which consists of a search for underlying meaning and structure, is said to lead to superior performance (Eley, 1992). Learning in this way is based on tasks that require personal involvement (as the care of someone who is dying should do). Such learning leads to reading about and understanding the issues highlighted by the tasks. Autobiographies and biographies that describe experiences of illness give us rich examples and a deeper understanding of the lifeworld of people who are dying (Hawkins, 1993).

In an attempt to facilitate a more reflective way of learning that may identify some turning points at an early stage in their career we have designed a programme that encourages reflection both in and on action. Throughout their undergraduate clinical career students are exposed to elements of end-of-life care (MacLeod & Robertson, 1999). At the Wellington School of Medicine this included a 1 h seminar in their first clinical year about the principles of palliative care and a further 1 h lecture on therapeutics for palliative care. In their second clinical year, palliative care shares four half-days with Oncology/Haematology looking at aspects of cancer care, including palliative care, during which the students meet and talk with people with

cancer. In their final year, students have a 2-day attachment to the hospice for clinical work in this field. Since the start of this year, students beginning their clinical undergraduate career are introduced to a family in which someone is dying. The students are asked to interview both patient and family, at least twice, over a period of 4 weeks. By including this experience at an early stage we hope to help them to focus on some of the less medical aspects of advancing disease and attempt to gain an understanding of what it is like to be facing death. The students are expected to create a portfolio that contains not only details of medical history and experiences but also a reflection on the aspects of care that are significant for the patient and family and any ethical issues that are raised. Students are also encouraged to write a reflective essay on what the experience was like for them on a personal level. They are encouraged to talk with course tutors to develop any areas of interest or concern. A seminar at the conclusion of this process gives each group of students (10–12 in number) an opportunity to discuss some of these more intangible issues that people are facing at the end of life. In this way we hope to encourage the students to identify their own turning points and to create opportunities for learning throughout their undergraduate careers that will fit them for a more caring approach in dealing with people at the end of life.

Initial evaluation of this new aspect of the curriculum has been positive. Students have enjoyed the patient contact and have been able to address issues that have not previously arisen. During and after their interviews they have identified aspects of care that had not previously been apparent and they have had opportunities to discuss ethical issues. Staff have also been positive about the process and outcomes so far. Qualitative analysis of the programme is being undertaken.

Conclusion

The care of people who are dying forms a significant part of almost all medical practitioners' work. Yet there is not sufficient evidence to suggest that formal undergraduate or postgraduate teaching has a significant enough effect in this area. The doctors in this study testified to learning about the care of dying people, in an emotional and intimate way, from those dying people. The challenge for educators is to identify ways in which this learning can be optimised and replicated constructively. The hospice movement has made a major contribution to medical practice in identifying ways to alleviate symptoms and to improve communication with people who are dying as well as their families, but there is still a long way to go. Until all doctors in training have had an opportunity to explore

their own concerns about death and dying and to enter the lifeworlds of dying people through personal experience, it will still be left to chance as to whether individuals encounter this most significant aspect of medical practice.

Encouraging the practice of reflection, journaling and creating portfolios will go some way to addressing this problem. However, until palliative medicine is truly incorporated into medical practice and until a corresponding understanding of "care" develops within the discipline of medicine, the danger remains that medical care at the end of life will become technologized and routine.

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Appendix A. The initial questions

How did you happen to choose medicine as a career?

Have you worked in any other area? What area? For how long?

What field of medicine do you/ will you work in? Why?

What is your idea of a successful doctor?

Do you think your training is/was good enough for you to handle everything you encounter in your practice?

There is a huge increase in medical knowledge — how do you decide what is important to learn?

Have you had any specific education or training about death and dying? Do you remember things in your undergraduate teaching about this?

Have you had any personal experience with dying people? Can you tell me about that?

What was your first experience of death (in a close relationship)?

Do you feel prepared to care for people who are dying?

Can you recall any particular people or events that have influenced the way that you care for people who are dying?

How have you learned to care for people who are dying?

What did you learn?

How has this influenced your practice?

Why was that learning significant? (Why did you learn that?)

Can you think of any other way that you have learned to care for people who are dying?

References

- Barnard, D. (1995). The promise of intimacy and the fear of our own undoing. *Journal of Palliative Care*, 11(4), 22–26.
- Barzansky, B., Veloski, J. J., Miller, R., & Jonas, H. S. (1999). Palliative care and end-of-life education. *Academic Medicine*, 74, S102–S104.
- Becker, H. S., Geer, B., Hughes, E. C., & Strauss, A. L. (1961/1977). *Boys in white* — student culture in medical school. (pp. 33–48, 273). New Brunswick: Transaction Publishers.
- Benner, P. (Ed.) (1994). *Interpretive phenomenology: embodiment, caring and ethics in health and illness*. (p. 79). Thousand Oaks, CA: Sage Publication.
- Billings, A. (1993). Medical education for hospice care: a selected bibliography with brief annotations. *Hospice Journal*, 9, 69–83.
- Billings, A., & Block, S. (1997). Palliative care in undergraduate medical education. *Journal of the American Medical Association*, 278(9), 733–738.
- Branch, W. T. (2000). The ethics of caring and medical education. *Academic Medicine*, 75, 127–132.
- Cantwell, D. M., & Ramirez, A. J. (1997). Doctor-patient communication: A study of junior house officers. *Medical Education*, 31, 17–21.
- Cushing, H. (1926). *The life of Sir William Osler*. New York: Oxford University Press.
- de Hennezel, M. (1998). Intimate distance. *European Journal of Palliative Care*, 5(2), 56–59.
- Eley, M. (1992). Differential adoption of study approaches within individual students. *Higher Education*, 23, 231–254.
- Emanuel, E. J. (1997). Time for education in palliative care. *Lancet*, 349, 1709–1710.
- Fendtner, C., Christakis, D. A., & Christakis, N. A. (1994). Do clinical clerks suffer ethical erosion?. *Students' perceptions of their ethical environment and personal development*. *Academic Medicine*, 69, 670–679.
- Field, D. (1995). Education for palliative care: Formal education about death, dying and bereavement in UK medical schools in 1983 and 1994. *Medical Education*, 29, 414–419.
- Field, D. (1999). Special not different: General practitioners accounts of their care of dying people. *Social Science & Medicine*, 46, 1111–1120.
- Field, M. (1997). The quality of dying: how can we improve end of life care?. *Journal on Quality Improvement*, 9, 498–504.
- Field, M. J., & Cassel, C. (Eds.) (1997). *Approaching death: Improving care at the end of life*. Institute of Medicine, Washington DC: National Academy Press.
- Fox, E. (1998). Predominance of the curative model of medical care. *Journal of the American Medical Association*, 278(9), 761–763.
- Hafferty, F. W. (1991). *Into the Valley: Death and the socialization of medical students* (pp. 182–187). New Haven: Yale University Press.
- Hawkins, A. H. (1993). *Reconstructing illness. Studies in pathography*. West Lafayette, Indiana: Purdue University Press.
- Jeffrey, D. (1994). Education in palliative care: A qualitative evaluation of the present debate about the needs of general practitioners and community nurses. *European Journal of Cancer Care*, 3, 67–74.
- Kolb, D. (1984). *Experiential learning*. Englewood Cliffs, NJ: Prentice Hall.
- Kutner, J. S., Steiner, J. F., Corbett, K. K., Jahnigen, D. W., & Barton, P. L. (1999). Information needs in terminal illness. *Social Science and Medicine*, 48, 1341–1352.
- MacLeod, R. D. (1994). Education in palliative medicine: A review. *Journal of Cancer Education*, 8, 309–312.
- MacLeod, R. D., & Nash, A. (1991). Teaching palliative care in general practice: A survey of educational needs and preferences. *Journal of Palliative Care*, 7(4), 9–12.
- MacLeod, R. D., & Robertson, G. R. (1999). Teaching about living and dying: Medical undergraduate palliative care education in Wellington, New Zealand. *Education for Health*, 12(2), 185–192.
- Merton, R. K., Reader, G. G., & Kendall, P. L. (Eds.) (1957). *The student-physician: Introductory studies in the sociology of medical education*. (p. 287). Cambridge: Harvard University Press.
- Moustakas, C. (1994). *Phenomenological research methods*. (p. 27). Thousand Oaks, CA: Sage Publications.
- Noddings, M. (1984). *Caring: A feminine approach to ethics and moral education*. Berkeley: University of California Press.
- Patten, M. Q. (1990). *Qualitative evaluation and research methods* (2nd ed.). Newbury Park, CA: Sage. In N.K. Denzin, & Y.S. Lincoln (Eds.) (1994). *Handbook of qualitative research*. Thousand Oaks, CA: Sage.
- Peabody, F. W., [1927] (1984). The care of the patient. *Journal of the American Medical Association* [88, 877–82] 252, 813–18.
- Seale, C. (1991). Communication and awareness about death: A study of a random sample of dying people. *Social Science and Medicine*, 32, 943–952.
- Seale, C., & Cartwright, A. (1994). *The year before death*. Avebury: Aldershot.
- van Hoofst, S. (1996). Bioethics and caring. *Journal of Medical Ethics*, 22, 83–89.
- van Manen, M. (1990). *Researching lived experience*. (p. 27). Albany: State University of New York Press (p. 27).
- Watson, J. (1988). Human care in nursing. In J. Watson. *Nursing: Human science and human care. A theory of nursing* (pp. 27–30). New York: National League for Nursing Press.

Appendix

Changing the way doctors learn to care for people who are dying

MacLeod, R.D. : 1992 : Symptom Control in Palliative Medicine and Terminal Care in : Rowe, M. (Ed.) BDHA Clinical Standards, BDHA, Bath, England

MacLeod, R.D., Vella-Brincat, J. : 1994: The Palliative Care Handbook, Dorothy House Foundation, Bath, England

MacLeod, R.D. and James, C.R. (eds): 1994 : Teaching palliative care: issues and implications Patten Press, Penzance, Cornwall, U.K.

MacLeod, R.D. and James, C.R. : 1994 : The context of education in palliative care Teaching palliative care: issues and implications Patten Press, Penzance, Cornwall, U.K.

James, C.R. and MacLeod, R.D. : 1994 : Teaching and learning in palliative care: future considerations Teaching palliative care: issues and implications Patten Press, Penzance, U.K.

MacLeod, R.D. : 1994 : Use of Bisphosphonates in Malignant Disease Network : 3:14: Cancer Society of New Zealand, Wellington

MacLeod, R.D. : 1994: Medical decisions at the end of life : New Zealand Medical Journal : 107: 253

Vella-Brincat, J., MacLeod, R.D. : 1995 : Symptom Control: Depression, insomnia and confusion. Pharmaceutical Journal : 254: 754-756

MacLeod, R.D. : 1995 : Managing physical symptoms (other than pain) New Ethicals 32 : 7 : 13-18

MacLeod, R.D. : 1995 : Palliative care in cancer patients New Ethicals Disease Index: 25-28

MacLeod, R.D. : 1995 : Palliative Care (editorial) New Ethicals 32 : 7 : 11

MacLeod, R.D. : 1995 : Intestinal Obstruction in Palliative Care in New Zealand Douglas Pharmaceuticals, Auckland, New Zealand

MacLeod, R.D., Vella-Brincat, J. : 1996 : The Palliative Care Handbook Ciba-Geigy, New Zealand

MacLeod, R.D. : 1997 : Advance directives New Zealand Family Physician 24 : 3, 25

Ashby, M., Brooksbank, M., Dunne, P., MacLeod, R.D. : 1997: Australasian Undergraduate Medical Palliative Care Curriculum. ANZSPM, Melbourne, Australia

MacLeod, R.D. : 1997: "All patients need doctors who care as well as cure". New Zealand Family Physician 24: 6, 7-9.

MacLeod, R.D. : 1998 : Palliative Care (towards 2000) New Ethicals Journal 1:1, 32.

MacLeod, R.D. : 1998 : Palliative Care New Ethicals Journal 1:5, 20-21.

MacLeod, R.D. : 1998 : Nausea and Vomiting in Palliative Care New Ethicals Journal 1:6, 41-46.

MacLeod, R.D., Carter, H. : 1999: Health professionals' perception of hope: understanding its significance in the care of people who are dying. Mortality 4:3, 309-317

Royle, D., MacLeod, R.D. : 1999: Management of constipation in palliative care. New Ethicals Journal 2:6, 55-59

Royle, D., MacLeod, R.D. : 1999: Management of malignant bone pain. New Ethicals Journal 2: 11, 23-29

MacLeod, R.D.: 2000: Respiratory symptoms in palliative care New Ethicals Journal 3:1, 61-64

MacLeod, R.D, Vella-Brincat, J.: 2000: The Palliative Care Handbook Novartis, New Zealand

MacLeod, R.D. : 2001: Dyspnoea – management: psychosocial therapies. Ahmedzai, S., Muers, M. (eds) Oxford Textbook – Supportive care in respiratory disease (in press)

MacLeod, R.D. 2001: Palliative care and the internet. New Ethicals Journal 4: 1(special feature), 25-29 + reprinted as special supplement April, 2001 p63-65

MacLeod, R.D. 2001: Cultural issues in end of life care. The Nathaniel Report 4, 12-13

MacLeod, R.D. 2001: Fatigue in people who are dying. New Ethicals Journal 4: 9, 41-44

MacLeod, R.D, Vella-Brincat, J., Macleod, A.D.: 2001 The Palliative Care Handbook (incorporating Nurse Maude palliative care formulary) NZIJ, New Zealand

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